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MICHIGAN MEDICINE

JULY 1992
VOL. 91, NO. 7

*Award-Winning
Journal of the
Michigan State
Medical Society*

Cover
Story

Practice Management MSMS has many services

Medical Inquirer

A look at
physician
characteristics

An update on Lyme disease

Also included:

- Soundoff!
- County Society News
- Reimbursement Roundup
- Physicians in the News



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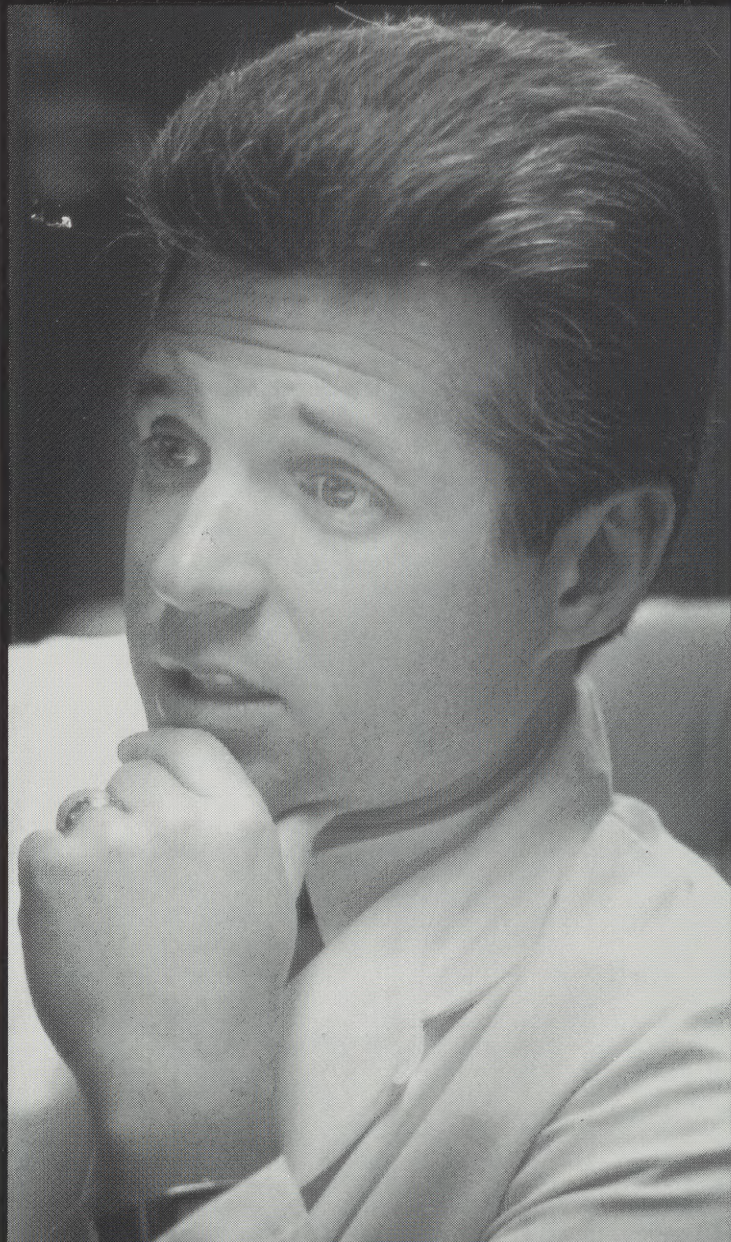
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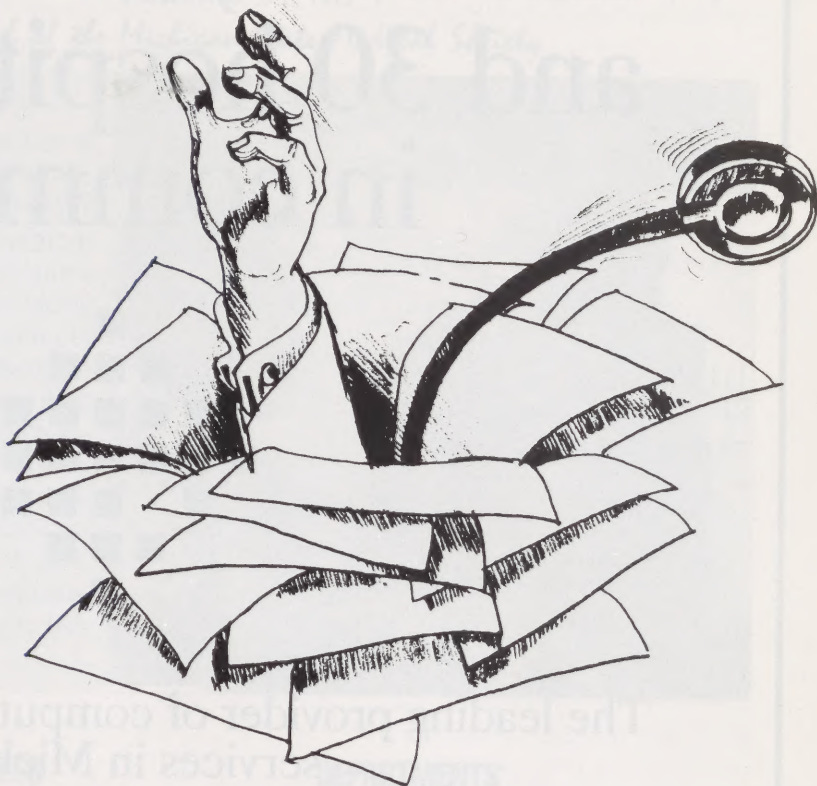
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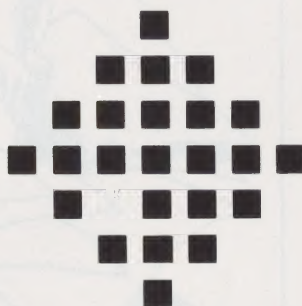
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MICHIGAN MEDICINE

JULY 1992

VOLUME 91, NO. 7

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

Like so many areas of today's society, the practice of medicine has become more complex. In 1992 alone, physician practices are grappling with a plethora of new regulations—from Medicare's new payment system to new OSHA requirements. This month's cover story recognizes the many challenges facing physicians and describes how MSMS is expanding its services to meet the growing needs of its physician members for practice management assistance. Also included is a practice management quiz which includes many important questions for physicians on such topics as Medicare billing procedures, compliance with OSHA's new Bloodborne Pathogens Standard, and proper documentation of patient care. Rounding out this month's cover story is an explanation of how Medical Billing Service is working to link the Blues to providers.



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Medical Inquirer

This is the ninth in a series of factsheets prepared by the MSMS Department of Medical Economics and Health Care Delivery featuring data and trends affecting Michigan physicians. The subject of this Inquirer: physician characteristics.

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Lyme Disease in Michigan

A report from the Disease Surveillance Section of the Michigan Department of Public Health reveals that very little Lyme disease occurs in lower peninsula Michigan.

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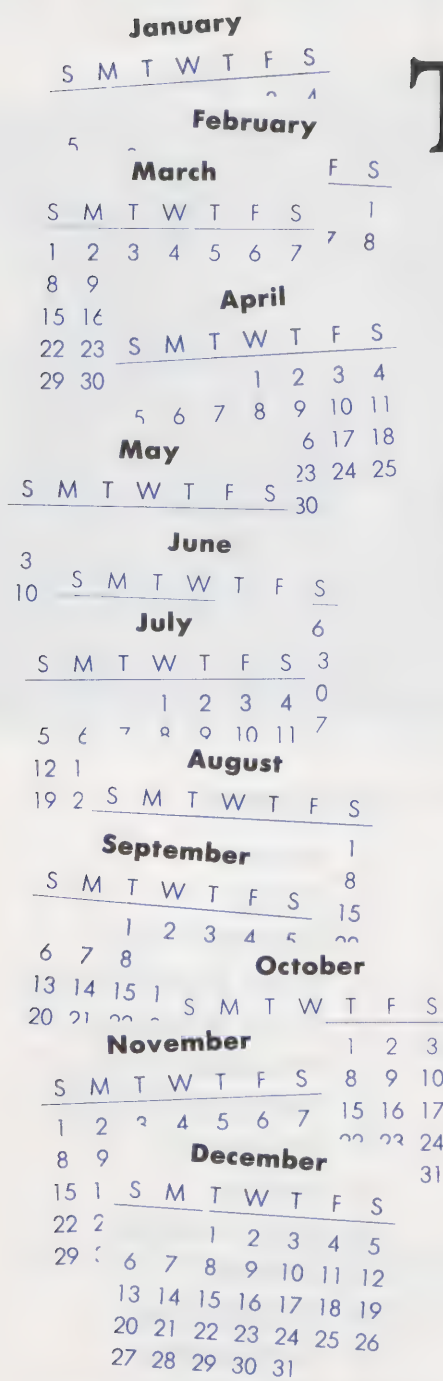
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In next month's issue:

MSMS House of Delegates
Proceedings

Cover illustration: By Robert L. Brent



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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. **Michigan Medicine** reserves the right to accept or reject advertising copy. Products and services advertised in **Michigan Medicine** are neither endorsed nor warranted by MSMS.

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SOUNDOFF!

Soundoff! provides MSMS members with the opportunity to voice their opinion about any issue they please. If you have an opinion you would like to share with your colleagues, write it down and send it to *Michigan Medicine*, PO Box 950, East Lansing, MI 48826-0950 Attn: Betty McNerney. We will do our best to publish your comments in a timely manner.

Long-range vision key to maintaining our profession

By F. Remington Sprague, MD

Editor's note: The following article is reprinted from the May 1992 issue of the Muskegon County Medical Society Newsletter.

In recent weeks I have had three experiences I want to share with you for the enlightenment they provide and the musings they stimulate.

In mid-April I was invited to address a group of businessmen, educators and union representatives about the pressures we physicians face in these times. The conference focused on wellness initiatives for area businesses but opened with a panel discussion wherein representatives of business, government, insurers and health care providers expressed their views of the problems with the current health care environment. I used the opportunity to talk about the impact of the liability climate on physician availability and practice patterns. More important than what I said was the fact that I was

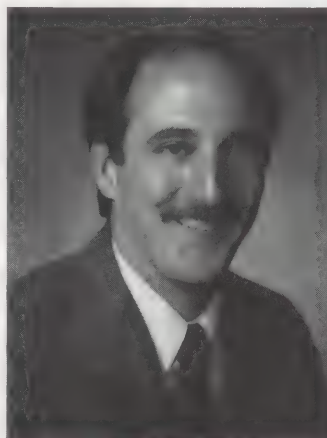
there. Not only did my presence indicate an interest by physicians in participating in this dialogue, it also served to inhibit other speakers from laying the blame for rising health care costs solely on our shoulders.

At the second meeting I found myself on the receiving end with little opportunity to express my own views or those of the Muskegon County Medical Society. An executive in charge of health care benefits for the nationwide employees of SPX spoke to a collection of hospital board

and medical staff members about his plans to stem the rise of health care costs by 50 percent. Limiting benefits, shifting part of the costs of those benefits remaining to employees, working through PPOs to achieve discounts from hospitals and doctors and expanding case management activities were a few of the

strategies he outlined. This was a clear and immediate example of the seriousness with which industry views the costs of providing health care to its employees and the preliminary steps they are taking to control them. Far more aggressive initiatives are being

Continued on following page



F. Remington Sprague, MD

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SOUNDOFF!

Continued from page 5

taken by larger employers — especially in areas where they employ a large percentage of the local community.

The third encounter, sponsored by Hackley Hospital, was with Hugh W. Long, PhD, a health care expert from Tulane University's A.B. Freeman School of Business. Doctor Long described in depth the current statistics of health care financing and the effects of benefit design and payment mechanisms on the behaviors of patients and providers (hospitals and doctors). He also talked about government strategies to limit health care expenditures in the face of growing budget deficits including all-inclusive payments to hospitals to cover the expenses (including physician fees) for a single illness. He made a strong case for closer hospital-physician collaboration.

Balance essential

It is essential for physicians to consider, with great care, the nature and extent of this collaboration. We must know where our interests merge and where they diverge from those of our hospitals. We must look beyond short-term financial gain and focus on a long-range vision which balances our interdependency with autonomy, which is essential to our role as healers of and advocates for our patients. To formulate this vision will require that we spend time in contemplation and discussion among ourselves and with experts, such as Doctor Long. Once formulated, teamwork will be needed to realize it. This can only be accomplished through mutual respect and support and cannot be built using the worn-out tools of manipulation, intimidation and control. The alternative is to sit back and let the current and future forces reshape our profession while we simply adapt and adjust until, finally, we cease to be professionals altogether and simply become hired help. ■

Doctor Sprague is president of the Muskegon County Medical Society.

LETTERS

Editor's Note: Following is a letter sent to then MSMS President Robert D. Burton, MD, from Eugene H. Boyle, MD, expressing his discontent with the Blue Cross-Blue Shield contract. Immediately following the letter is Doctor Burton's letter of response. Both are reprinted verbatim.

MSMS must get tough with the Blues

Dear Doctor Burton,

I am reluctantly sending my medical dues for the Wayne County Medical Society, MSMS and the AMA for the coming year. The reason for my discontent is the poor leadership in regard to the Blue Cross-Blue Shield contract. There seems to be too much reliance on goodwill negotiations with an organization that pays very little attention to the doctors in this state. A few years ago, the chiefs of the departments of anesthesiology at most major Detroit area hospitals met with the BCBSM representative in regard to certain procedures dealing with obstetrical anesthesia. They paid little or no attention and were practically insulting in their attitude. Our own department had a dispute with them and, it wasn't until we hired a lawyer, that they paid any attention to us. Lawyers they understand.

It is bad enough that we are underpaid in relation to the neighboring states but there were other provisions in that contract that had nothing to do with economic matters. I am well aware of the restraint on antitrust laws but that contract took away almost every right provided for in Public Law 350. As you well know, too many doctors are willing to sign anything put in front of them in order to be paid. It is up to our societies to point out the negative factors; at least in non economic matters.

The seed money provided by the Anesthesiologists For Equity, the osteopaths and a few others has already produced some results. Do you really believe BCBSM would have granted the recent increase in fees if they weren't under the gun as a result of the suit brought by Andrew Wachler? Maybe MSMS has too many people in sensitive positions that are salaried employees of hospitals. They do not suffer the same consequences as those of us who are fee for service practitioners.

I, and many of my colleagues, will be watching MSMS and looking for leadership in the coming year. They have appeared to join the fight now as followers. We will expect more in the future. We have enough people who are trying to destroy private practice. If we have to hire lawyers to fight our battles, then maybe that's where our resources will have to be spent. ①

Eugene H. Boyle, MD
Grosse Pointe Shores

MSMS targets improved BCBSM payments to physicians

Dear Doctor Boyle:

Thank you for your recent letter regarding your membership renewal and MSMS activities related to Blue Cross Blue Shield of Michigan. I appreciate this opportunity to respond to your concerns.

In your letter, you asked if I believed that the Blues' payment increase to physicians would have been approved in the absence of the appeal related to the Blues' 1987-88 Medical Doctors Provider Class Plan. Yes, I do. As you may know, the 1990 contract created a Physician Contract Advisory Committee with representation from MSMS, MAOP&S and the BCBSM

Board of Directors. Since the Committee's inception in the fall of 1990, payment levels have been a priority for our representatives to the Committee. At the insistence of MSMS representatives to the Committee, BCBSM last fall reviewed its payment levels as called for by the contract. The result of the review was the recommendation by BCBSM representatives to the Committee that their Board of Directors approve the payment increase that (took) effect on April 1, 1992.

MSMS plans further work on the issue of payment. As you know, a 1989 study commissioned by BCBSM revealed that Blues' payment to Michigan physicians is 40 percent less than payment in five neighboring states. A frequent response of BCBSM management and customers to our concern over this finding is that Michigan physicians demonstrate higher patterns of use than in other states. Over the next several months, an independent researcher agreed to by MSMS, MAOP&S and BCBSM will reexamine the difference in payment and use between Michigan and surrounding states and will explore some of the factors that contribute to those differences including liability, health status indicators and administrative costs. We believe the study will give us further ammunition to improve payment levels and to argue against cost containment programs directed solely at restricting payment to physicians.

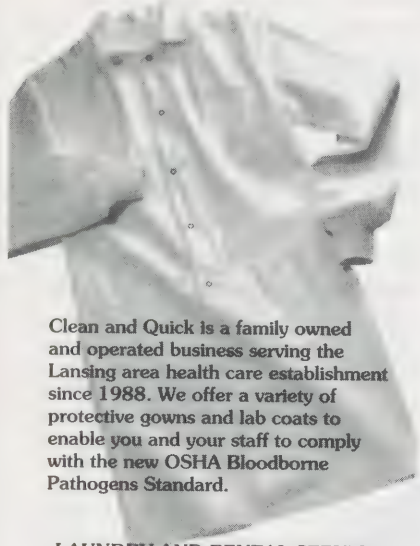
MSMS is active in several other arenas and on many other issues. The work of our Liaison Committee with BCBSM on 44 issues identified as reasons for low participation by physicians in Western Michigan led

Continued on following page

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LETTERS

Continued from page 7

to the elimination of 854 procedures from preauthorization requirements, to dramatic improvement in BCBSM's Provider Inquiry Department and to enhancement of systems for physicians to obtain benefit information. These service improvement will continue with the release of new service manuals for physicians and office staff this year.

MSMS efforts led to introduction of SB 432 which addressed important issues related to medical necessity, appeals and service standards. This spring, the House of Representatives Committee on Insurance plans an examination of BCBSM policies and practices and MSMS plans active involvement in legislators' deliberations on Blues' reforms.

MSMS has met with the Michigan Insurance Commissioner to discuss concerns over the Provider Class Plan and obtained his commitment to seek MSMS input in future plans. To prepare for this input, we have convened a Task Force to identify issues of importance to physicians that must be addressed in a Provider Class Plan. Members of the Task Force include: Gary D. Maynard, MD, Chairman; Susan Hershberg Adelman, MD; John J. Billi, MD; Robert J. Galacz, MD; Donald B. Muenk, MD; Steven E. Olchowski, MD; Frederick W. Van Dwyne, MD and Stanley B. Wolfe, MD.

Seeking change to the appeals process is an important part of our efforts. Last fall, our Board of Director directed MSMS to use all available forums to pursue a simplified appeals process that would extend to issues and disputes not currently covered under appeal rights in the contract. We are seeking these changes through the Legislature, the Physician Contract Advisory Committee and, ultimately, the

Provider Class Plan.

As you point out, the contract itself has many flaws and we will continue to use all available avenues to correct those flaws. However, it is important to realize that MSMS commented on early drafts of the contract and that the response to our comments resulted in several improvements. Obviously, some of our concerns were not addressed in the final contract, which is why physicians need to work together in pursuit of needed changes.

The commitment of many MSMS members who serve on our committees and task forces related to BCBSM has produced a number of improvements. Unfortunately, there are no "quickfixes" for many of the problems that confront physicians in their relationship with BCBSM and the task of resolving those problems is ongoing. Our strategy for seeking changes has made judicious use of member dues, assuring that we do not divert resources from other important activities such as liability reform, public health, continuing medical education, practice management education, MPRO and legislation.

I thank you for your commitment to our work in all of these areas through your membership renewal. I feel confident that the year ahead will produce further success in some of the issues that are of concern to you. In the meantime, I hope you will continue to share your concerns and comments about Blue Cross Blue Shield and other issues.

Robert D. Burton, MD
MSMS President

A monthly update of key MSMS activities



MSMS to lead family violence prevention efforts

Next month MSMS will initiate brainstorming with Michigan community leaders on how to prevent family violence. To help create physician and public awareness about the issue, MSMS will conduct a series of forums to spur discussion. MSMS President Thomas C. Payne, MD, will lead a news conference preceding the first forum Aug. 19. The topic is a theme of Doctor Payne's presidency and also will be featured as the cover story of September's *Michigan Medicine*.

1992 MSMS Annual Scientific Meeting course topics include family violence, physician-assisted suicide

Three courses on family violence are among the more than 50 courses to be offered at the Nov. 17-19 MSMS Annual Scientific Meeting. Doctor Payne will lead the sessions, which are part of the MSMS physician awareness campaign on family violence prevention. MSMS also is planning a day-long symposium on the topic just prior to the annual meeting.

Other events at this year's meeting include a plenary session and course on physician-assisted suicide. Actress, singer and breast cancer survivor Ann Jillian will speak to meeting attendees about the hopeful side of breast cancer. Watch for a preliminary meeting program, course list and registration form in the Aug. 25 *Medigram*. The entire October issue of *Michigan Medicine* will serve as a final meeting program, complete with details and features about the meeting.

Hepatitis B vaccine discounted for MSMS members

Physicians may obtain hepatitis B vaccine at a discounted rate from Bond Wholesale Pharmaceutical and Medical Supply. MSMS negotiated the price of \$39.99 per vial to aid physicians in meeting federal requirements effective this month. Under the regulations, employers must vaccinate employees exposed to blood-borne diseases such as hepatitis B. Each vial provides one shot, and a series of three shots is needed per person. Physicians can order by calling Sandy at 1-800-989-1199 or faxing their orders to 1-602-470-1573.

MSMS to hold Editor's Workshop for County/Specialty Society Bulletin Editors

MSMS will conduct an editor's workshop July 22 for county and specialty society bulletin editors at its East Lansing headquarters from 1:00 p.m. to 4:00 p.m. The workshop will feature a session on editing and design; a session on computer software options; a panel discussion by bulletin editors; a brief presentation by MSMS' subsidiary, Abbott Press; and a question and answer session. The cost is \$35 per person. Call Betty McNerney at MSMS for further information or to register.

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County Medical Societies **ON THE GO**

On the Go highlights the activities of county medical societies in Michigan. If the activities of your county medical society are not mentioned in this feature and you have some news you would like to share, please contact Helen Fordham at MSMS.



Historical photographs and medical instruments from the last century were on display at Flint's Sloane Museum throughout May and June.

GENESEE

■ Genesee County Medical Society celebrated its 150th Anniversary May 16 at the Flint Golf Club. Over 240 people attended the event. State Representative Dale Kildee, Senator Joseph Conroy and Mayor Woodrow Stanley were among the distinguished guests. While not physically present, President Bush was also among those who congratulated the society for its 150 years of service. President Bush expressed his salutations in a letter.

Flint's Sloane Museum and Genesee County Medical Society collaborated to produce an exhibit entitled, "Medicine: 1841 to the Present." The exhibit, open May and June, included photos and medical instruments from the last century. Gary Johnson, MD and Vivian Lewis, MD, helped set up the exhibit.

ST. CLAIR

■ St Clair County Medical Society held pre-participation sports screenings for local school children in early June. Gary Doss, DO, Port Huron, organized several physicians to examine 1,200 children.

St. Clair County also hosted a Focus Group Meeting June 10 for members of the MSMS Section for International Medical Graduates. Over 40 physicians attended the meeting to discuss the challenges and opportunities facing IMGs and what organized medicine is doing on their behalf.



Approximately 40 international medical graduates from St. Clair and other nearby counties attended a focus group discussion at Port Huron Hospital June 10. Shown at the podium is MSMS Board Chairman Jack L. Barry, MD, who updated attendees on key MSMS activities.

WASHTENAW

■ Washtenaw County Medical Society, in conjunction with the Washtenaw County Bar Association hosted a program on domestic violence and abuse May 12. This was the second meeting the society has held in an effort to heighten public and physician awareness of the issue. Representatives from the county bar association, medical so-

ciety and law enforcement agencies attended this evening meeting.

WAYNE

■ Physicians who attended Wayne County's general membership meeting in June had the opportunity to hear Dennis Schornack, senior policy advisor to Governor Engler, discuss "Health Care in Michigan: Opportunities and Challenges."

SAGINAW AND OAKLAND

■ Saginaw and Oakland counties continue to work with community organizations to implement the MSMS Senior Courtesy Card Program. The program is designed to encourage below-poverty-line seniors to seek medical care. ■

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Fear keeps many physicians from intervening in domestic abuse cases, AMA reports

Factors such as discomfort, fear of offending, powerlessness, and time constraints prevent a majority of physicians from intervening in cases of domestic violence, according to a study published recently in the *Journal of the American Medical Association* (JAMA).

The study of 38 primary care physicians, predominantly (89 percent) family practitioners, between August 1990 and February 1991 found that many raised the image of opening Pandora's box to describe their reaction to exploring domestic violence with patients.

Author Nancy Kathleen Sugg, MD, and colleagues from the Division of General Internal Medicine, University of Washington, Seattle, write: "The issues raised in this study need to be addressed for physicians to develop a non-threatening approach to domestic violence that will no longer raise the specter of Pandora's box."

The study consisted of interviews with 38 physicians associated with a large, urban health maintenance organization (HMO) that serves predominantly white and middle-income patients with some education beyond high school. Of the 38 physicians interviewed, 63 percent were men and 37 percent were women, with a mean age of 41.

Eighteen percent used the phrase "Pandora's box," and eight percent used other phrases like "opening a can of worms" to explain their reluctance to intervene in domestic violence cases.

Thirty-nine percent said close identification with their white, middle-class patients may have pre-

vented them from considering the possibility of domestic violence in their differential diagnosis. Many physicians admitted they were more likely to ask patients of lower socioeconomic status about abuse.

Fear of offending patients was one of the strongest barriers expressed by physicians. Fifty-five percent felt that if they even broached the subject of violence, the patient would take offense at the implication of the question.

Fifty percent voiced frustration and feelings of inadequacy when discussing appropriate interventions. Many pointed to the complexity of the problem and the fact that they had no "tools" to help.

Sixty-one percent of the physicians interviewed revealed that they had no training in medical school, residency, or continuing medical education courses on intimate partner violence. Only eight percent said they had received good training on the problem.

Seventy-one percent said time constraints of a busy primary care practice are the major deterrent for asking about violence in the home. Their greatest fear was that domestic violence would consume more of their scarce time.

Michigan's immunization requirements updated

The Michigan Department of Public Health (MDPH) has new regulations in place to assure more effective and complete vaccination protection. The updated requirements went into effect April 24.

Under the new regulations, a licensed day care center or nursery school must require age appropriate vaccination with Hib (haemophilus influenzae type b) vaccine. The other vaccines, including DTP (diphtheria,

tetanus, pertussis), OPV (oral polio vaccine), and MMR (measles, mumps, rubella) are still required, depending on the child's age.

In response to the major measles outbreaks throughout the state and country, the improved regulations also require a second boosting dose of MMR for students 4-18 years of age who are entering school for the first time, or are in the process of transferring to a new school district.

Stressful events not linked to onset of AIDS symptoms in HIV-positive men, U-M reports

Stressful life events do not appear to trigger the development of AIDS symptoms in HIV-positive men who are feeling healthy, according to a University of Michigan study.

The investigators came to this conclusion after correlating the health and psychological status of 980 homosexual men in Chicago who were participating in two studies in 1984-87: the national Multicenter AIDS Cohort Study, which collected biomedical data, and the Coping and Change Study, a behavioral and psychological study funded by the National Institute of Mental Health.

The data, collected semiannually, included the occurrence and nature of stressful life events and the development of three HIV symptoms — fevers lasting longer than two weeks, bacterial infections of the throat and mouth, and declines of 25 percent or more in the number of T-helper lymphocyte cells.

NIH Consensus Panel Issues Report on Acoustic Neuroma

A National Institutes of Health (NIH) consensus development statement on Acoustic Neuroma

Continued on following page

Continued from page 13

may be obtained from the NIH Office of Medical Applications of Research (OMAR).

The report was prepared by a panel of experts who considered scientific evidence presented at a Consensus Development Conference at NIH. It contains recommendations and conclusions concerning acoustic neuroma.

At NIH, consensus conferences bring together researchers, practicing physicians, representatives of public interest groups, consumers, and others to carry out scientific assessments of drugs, devices, and procedures in an effort to evaluate their safety and effectiveness.

Free, single copies of the consensus statement on acoustic neuroma may be obtained from: William H. Hall, Director of Communications,

Office of Medical Applications of Research, National Institutes of Health, Building 1, Room 259, Bethesda, Maryland 20892, (301) 496-1143.

Most physicians have treated an HIV-positive patient, AMA reports

More than four out of five physicians in the US have treated at least one patient infected with the AIDS virus, according to a Gallup poll recently released by the American Medical Association.

In responding to the AMA's periodic poll on Health Care Issues, 82 percent of respondents said they had treated an HIV-positive patient, with even more younger physicians answering in the affirmative.

Ninety-four percent of physicians under age 35 said they had treated an HIV-positive patient; 61 percent of those 65 or over said that they had done so. Regionally, physicians in the Northeast were most likely to have seen an HIV-positive patient (88 percent) while those in the North-Central states were least likely to have done so (76 percent).

Physicians in metropolitan counties were found more likely (84 percent) than those in non-metropolitan areas (66 percent) to have treated an HIV-positive patient.

Eighty-one percent of physician respondents maintained that physicians have a right to know whether a patient is HIV-infected before offering treatment. A still higher figure—87 percent—believe that a physician who is HIV-positive should either obtain a patient's informed consent or refrain from performing significant invasive procedures. Physicians split almost evenly over the necessity of testing all hospitalized patients.

BCBSM issues new guide

Physicians should now have a copy of the new BCBSM *Guide for Physicians and Medical Assistants*—Volume one. The guide replaces the Blues' old *Physicians Manual*.

The new *Guide* is separated into three binders, the first of which is titled "What's Covered and How to File Claims." The other two volumes will be devoted to utilization management programs and administrative procedures.

Volume One: "What's Covered & How To File Claims" is designed for ease of use with larger typefaces, shorter sentences, illustrations, tabbed sections, and an index.

The Blues' is planning to publish Volume Two, "Utilization and Cost Management" later in 1992 and Volume Three, "Administration," in late 1992 or early 1993.

DDT can cause pancreas cancer in humans, U-M reports

For the first time, researchers have clear evidence, based on human mortality, that heavy exposure to DDT, an insecticide manufactured in the United States from 1945 to 1985, substantially increases the risk of pancreas cancer in human beings.

The study, conducted by researchers at the University of Michigan School of Public Health and the University of Southern California School of Medicine, is based on mortality records and interviews with next of kin from a sub-sample of 5,886 chemical workers.

All the workers, who were followed until 1987, were employed in chemical manufacturing at various times between 1948 and 1971. The sub-sample consisted of 28 men with verified pancreas cancer and another 112 men—a control group—who did not have pancreas cancer. The pattern of exposure to DDT in these two groups was compared.

According to David H. Garabrant, U-M associate professor of occupational medicine, the pancreas cancer risk for those who had ever been exposed to DDT during manufacture was 4.8 times as great as it was for those never exposed.

"Risk increased with both duration of exposure and the length of time since the first exposure," he added. Among subjects who had the longest exposure, the risk was 7.4 times as great as for those never exposed. This group had a median exposure of 47 months.

Workers who manufactured DDT had exposure levels that were hundreds of times more intense than it was for consumers, Garabrant noted. "The degree of risk to consumers, however, is not clear." ■

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PHYSICIANS IN THE NEWS

Earl J. Rudner, MD,

recently received the Distinguished Alumni Award from the Wayne State University School of Medicine.



Doctor Rudner is a clinical associate professor of dermatology at the WSU. He was chief resident in the department of dermatology at WSU. In 1967, he opened the first Contact Dermatitis clinic at Detroit Receiving Hospital. In 1970, he left the University on a full-time basis to concentrate on his private

practice in Southfield.

Robert E. Mack, MD,

recently received the Lawrence M. Weiner Award from the Wayne State University School of Medicine.



Doctor Mack is senior vice president for medical and educational affairs for the Detroit Medical Center and is assistant dean for medical center relations at WSU. He joined the School of Medicine in 1961 and served as president of Hutzel Hospital from 1970-1980.

Thomas E. Stone, MD,

is a newly-elected member of the Board of Directors of MPMLC. He will serve a three-year term. Doctor Stone, a Muskegon urologist, is a member of the MSMS Board of Directors.

Howard V. Dubin, MD,

is the new president of the Dermatology Foundation. Doctor Dubin is a clinical professor of dermatology at the University of Michigan Medical Center and is a private practitioner in Ann Arbor.

James N. Wardell, MD,

is recipient of the Nyswander-Dole Award for his significant contribution and dedication to the methadone treatment field. Doctor Wardell is

medical director of the Eleonore Hutzel Recovery Center at Hutzel Hospital. The Eleonore Hutzel Recovery Center is a nationally known program which treats substance abusing pregnant and non-pregnant women and their school-age children. Doctor Wardell was recently honored by the National Association for Perinatal Addiction Research and Education for his 22 years of research and intervention in the treatment of mothers and children born at risk to exposure to drugs and alcohol.

G. Marie Swanson, MD,

is a newly-appointed member of the national commission to study the state of breast cancer research, prevention, detection and treatment in the United States. Doctor Swanson is the director of the Cancer Center at Michigan State University. Her appointment to the Special Commission on Breast Cancer was announced by Vice President Dan Quayle. The 17-member commission's task will be to develop a report on methods to reduce breast cancer death rates. The commission is expected to meet 14 times over the next 18 months before preparing its report. Doctor Swanson is chairperson of the Michigan Department of Public Health's Breast Cancer Task Force, co-chair of the MDPH Cancer Consortium, and vice president of the American Cancer Society, Michigan division.

Nina Fukunaga, MD,

is recipient of a Young Investigator Award from the American Society of Clinical Oncology. The award carries with it a research grant for \$26,500, funded by Glaxo Pharmaceuticals. Doctor Fukunaga is chief resident at the Department of Radiation Oncology, Division of Cancer Biology, at the University of Michigan, Ann Arbor.

The Michigan Society of Anesthesiologists recently elected a new slate of officers. They are: **Tom George, MD**, president; **Bert Bez, DO**, president-elect; and **David Krhovsky, MD**, secretary-treasurer. ■

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MSMS Reimbursement Roundup



By Joyce Nurenberg

MSMS REIMBURSEMENT OMBUDSMAN

Reimbursement Roundup addresses third party payor reimbursement issues affecting physician practices. Comments and problems brought to the attention of the Reimbursement Ombudsman are routinely shared with the Liaison Committee with Blue Cross and Blue Shield of Michigan and its Subcommittee on Medicare Carrier Problems.

EDITOR'S NOTE: This month's Reimbursement Roundup was prepared by Thomas R. Williams, of Kerr, Russell and Weber, a Detroit-based law firm which provides legal counsel for MSMS.

Balance Billing of Secondary Insurance by Blue Cross Participating Physicians

The practice of billing the excess of charges over reimbursement by Blue Cross Blue Shield of Michigan (BCBSM), or "balance billing," raises issues of legal interpretation for physicians who participate with BCBSM. Physicians who have signed the Physician and Professional Provider Participation Agreement (Participation Agreement) with BCBSM are contractually required to accept BCBSM's payment as full reimbursement for covered services and, except under limited circumstances, may not collect any further payment from the BCBSM subscribers. Public Act 350 further provides that physicians participating with BCBSM on a per claim basis must certify that they will accept payment from BCBSM as payment in full for services rendered.

Although BCBSM participating physicians may not balance bill their patients, is balance billing of sec-

ondary insurance carriers permitted? When the secondary carrier is a no-fault automobile insurance carrier, the question has been settled by the Michigan courts. In 1985, the Michigan Court of Appeals ruled that a BCBSM participating provider may not balance bill a secondary no-fault automobile carrier for services covered by BCBSM. The case was *Dean v Auto Club Insurance Association*, 139 Mich App 266 (1985). Leave to appeal to the Michigan Supreme Court was denied the following year. In *Dean* the plaintiffs were chiropractors participating with BCBSM who

performed services on many patients who had been involved in automobile accidents and who were both BCBSM subscribers and insureds of the defendant Auto Club Insurance Association (ACIA). ACIA refused to pay the difference between BCBSM's reimbursement and the chiropractor's customary charges for services. The chiropractors filed suit and the lower court granted summary judgment for ACIA. On appeal, the court focused on the clear legislative intent in both the no-fault statute and Act 350 to

Continued on page 21

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Reimbursement Roundup

Continued from page 19

control health care costs in Michigan. The court stated that "plaintiffs may not participate in the BCBSM health care plan and then frustrate the legislative attempt to contain health care costs by simply seeking payment on the excess from no-fault insurers." The court emphasized that its holding was a matter of important public policy.

Dean remains valid law in Michigan and has been followed in subsequent cases.

Because Act 350 precludes balance billing only with respect to per claim participation and not for physicians who have signed participation agreements with BCBSM, BCBSM arguably could have authorized balance billing to secondary insurers in the Participation Agreement. However it declined to do so in the final draft. The Participation

Agreement states that "physician will accept BCBSM payment as full payment for covered services...and agrees not to collect any further payment from any member..." Since this language is limited only to members, balance billing of secondary insurers is not specifically prohibited. Although *Dean* is controlling as to no-fault carriers, there are no appellate cases dealing with the issue of balance billing of other kinds of insurance.

Whether these facts are sufficient to affect the payment policies of secondary payors is unknown at this time. However MSMS will pursue the issue and provide updates in *Medigram*. ■

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Primary functions of this physician leader are: 1) facilitate interaction and communication among the patient care staff, medical staff, executive management, Divisional Board of Trustees and Mercy's Community Health Care System as related to medical affairs; 2) Direct the development and implementation of clinical and organizational policies under which physicians practice.

Search deadline; August 19, 1992. Contact Kay Sineath, Mercy Hospital, 1500 E. Sherman, Muskegon, Michigan 49443; (616) 739-3903 EOE

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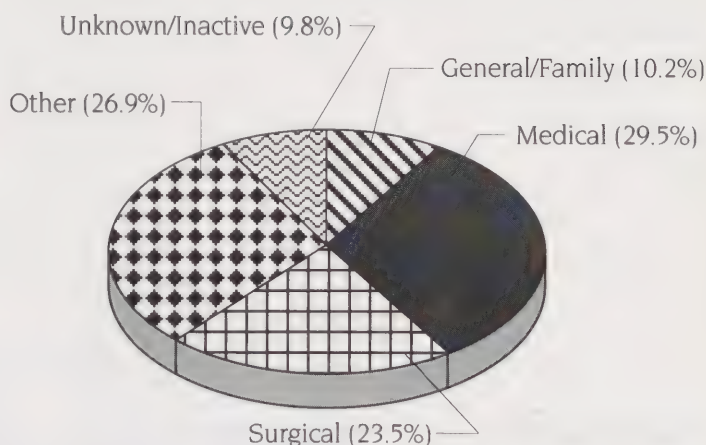
MEDICAL INQUIRER

DATA AND TRENDS AFFECTING MICHIGAN PHYSICIANS from the MSMS Department of Medical Economics and Health Care Delivery



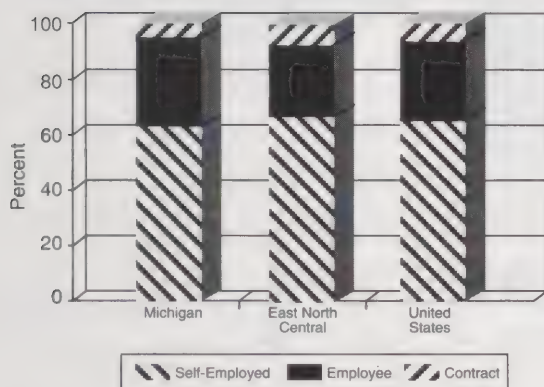
Physician Characteristics

Michigan citizens are cared for by physicians in a variety of specialties and practice settings. In 1991, there were 18,620 MDs in the state, and 84 percent of these physicians were involved in direct patient care. The following 1991 data was collected by the American Medical Association through its Physician Masterfile and the Socioeconomic Monitoring Survey.



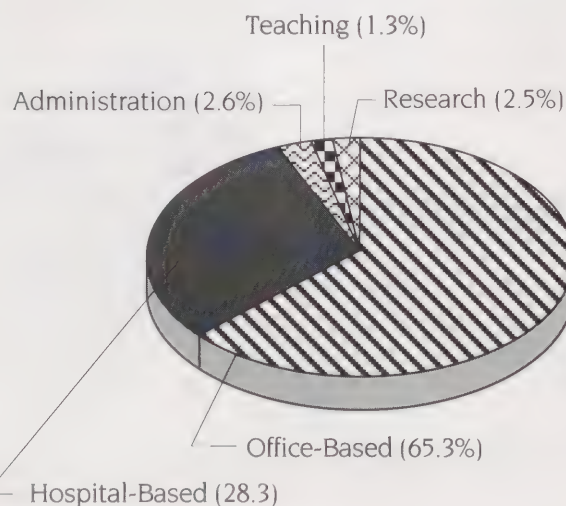
Michigan Physicians by Specialty

Ten percent of Michigan's physicians deliver primary care services. The largest group of physicians are in medical specialties, with nearly 60 percent of those specializing in internal medicine. Those physicians categorized under "other" run the spectrum from aerospace medicine to radiation oncology.



Employment Status

Michigan has a smaller percentage of physicians that are self employed than the region or the nation. Sixty-three percent are self-employed, 33 percent are employees, and the remaining 4 percent are independent contractors.

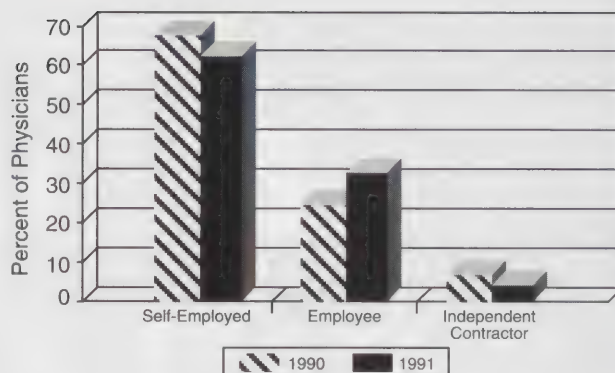


Michigan Physicians by Activity

Two-thirds of the state's physicians are office-based, in either group or solo practice. Twenty-eight percent are hospital-based, and the remainder are involved in medical education, scientific study or management.

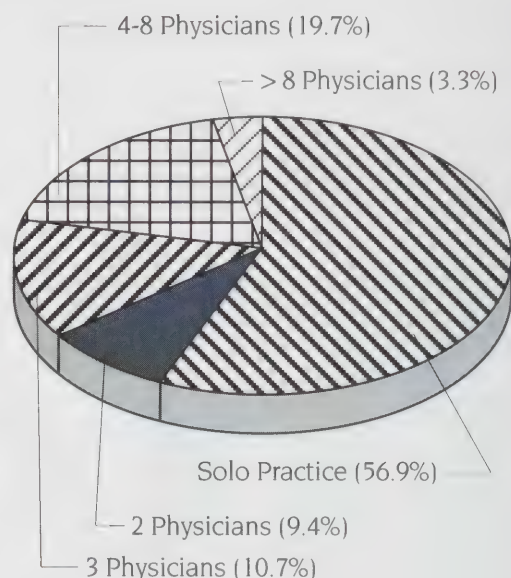
Change in Employment Status

In 1991 fewer Michigan physicians were self-employed (63 percent) or independent contractors (4 percent) than in the previous year. One-third of physicians were employees in 1991, an increase of 8 percentage points from 1990.



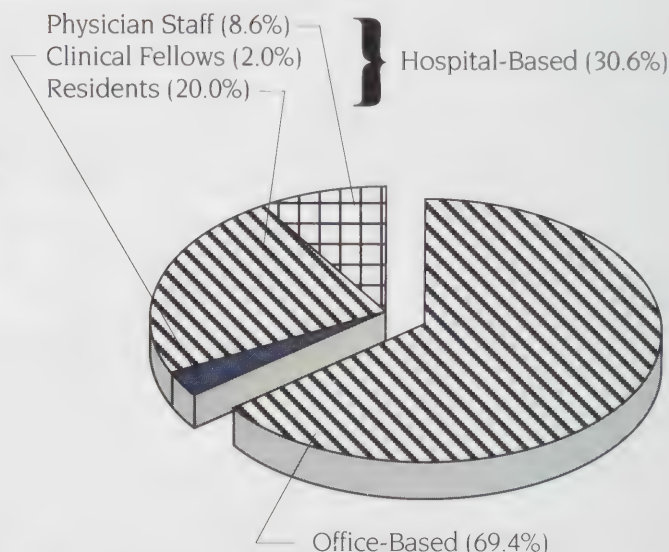
Size of Practice

The majority of physicians in Michigan are still solo practitioners, although that number had decreased five percentage points since 1990. The second most common practice size is 4 to 8 physicians. The smallest proportion was in practices with greater than 8 physicians.



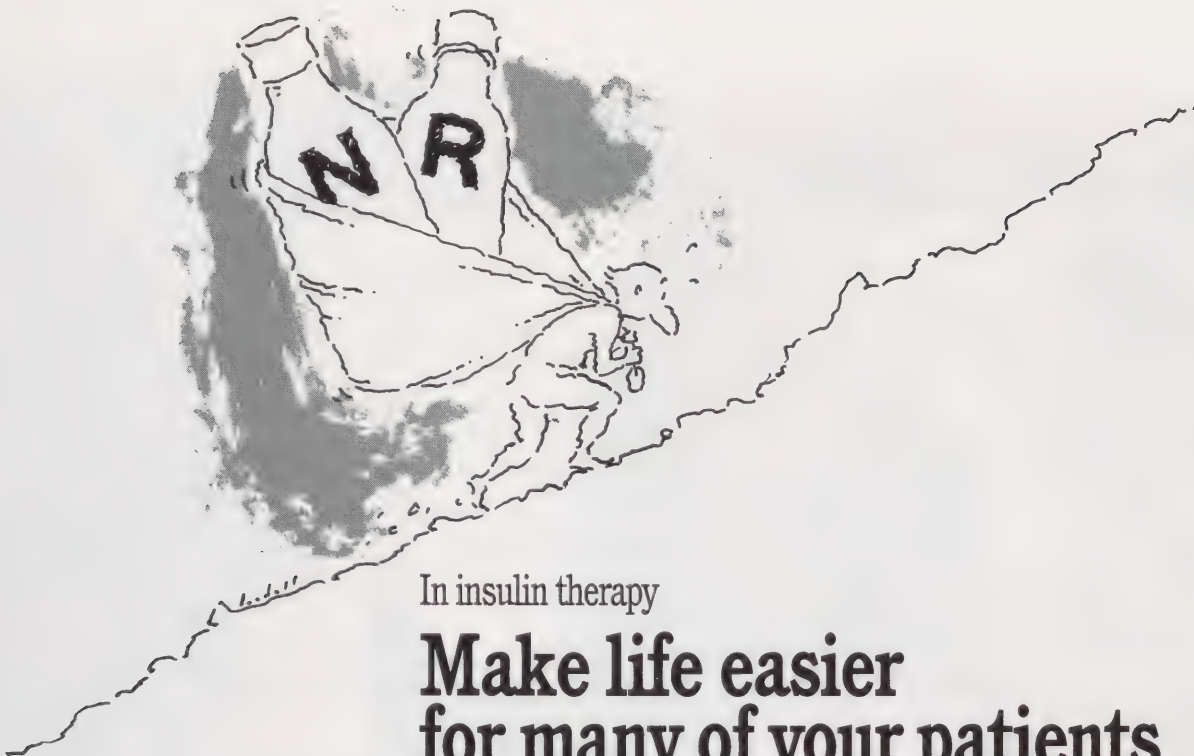
Patient Care Physicians

Patient care physicians, which excludes teaching, research and administration, were primarily office-based. Hospital-based physicians include 20 percent residents and 2 percent fellows.



SOURCE: American Medical Association, *Physician Characteristics and Distribution in the U.S.*, 1990 and 1992 editions, and *Physician Marketplace Statistics*, 1990 and 1991 editions.

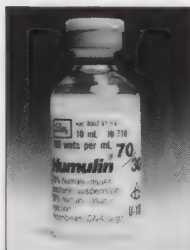
For further details on trends and sources of information, please contact Julie Lester at MSMS.



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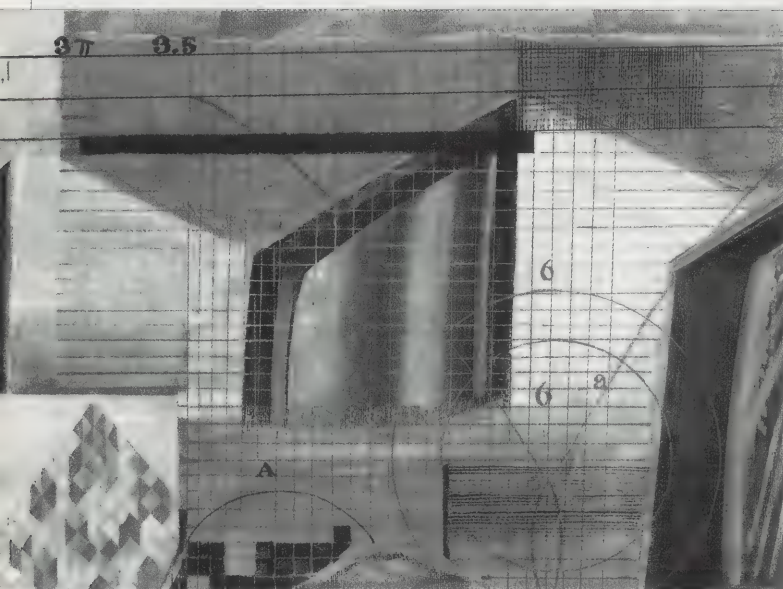
Cover
Story

Practice Management

MSMS Practice Management Services Expand to Meet Members' Changing Needs

Like so many areas of today's society, the practice of medicine has become more complex. In 1992 alone, physician practices are grappling with a plethora of new regulations—from Medicare's new payment system to new OSHA requirements. This month's cover story recognizes the many challenges facing physicians and describes how MSMS is expanding its services to meet the growing needs of its physician members for practice management assistance. Also included is a practice management quiz which includes many important questions for physicians on such topics as Medicare billing procedures, compliance with OSHA's new Bloodborne Pathogens Standard, and proper documentation of patient care. Try your hand at the quiz and see if you need to learn more about these important subjects. Rounding out this month's cover story is a brief explanation of how Medical Billing Service is working to link the Blues to providers. 

Expansion of MSMS Practice Management Services Underway



By Mary Anne Ford

Like so many areas of today's society, the practice of medicine has become more complex. In 1992 alone, physician practices are grappling with a new Medicare payment system, safe harbor regulations, new codes for reporting office services and new Occupational Safety and Health requirements. It's no wonder that so many physicians feel they are drowning in a sea of paperwork and that they are looking to their medical society for the information and service they need to achieve the balance between the patient care and business sides of their practices.

Recognizing members' growing needs for practice management assistance, MSMS is expanding its resources for members. A new Advisory Committee on Practice Management, chaired by Victor G. Sonnino, MD, of Midland, will begin meeting this month to help MSMS plan for meeting members' current and future needs.

MSMS already has begun expanding its services. Our first practice management programs in 1988 included 12 seminars. This year, over 70 programs were offered throughout the

state, including more than 20 programs on the new Medicare payment system, seminars on compliance with Occupational Safety and Health Administration (OSHA) regulations, and updates on regulatory trends affecting physician practices. A calendar of programs planned for the rest of 1992 begins on page 35.

Included in the calendar are Risk Management/Closed Claim Review Sessions, which are jointly sponsored by MSMS and the Michigan Physicians Mutual Liability Company (MPMLC). Closed Claim Review Sessions are roundtable discussions of two actual closed Michigan malpractice cases. MSMS and MPMLC have offered the specialty specific programs throughout the state since 1991. These extremely successful programs have provided physicians who participate with the opportunity to explore risk prevention ideas they can incorporate into their practices. Physicians who attend the programs are eligible for premium reductions from both MPMLC and the Physicians Insurance Company of Michigan (PICOM).

Helping physicians cope with regulations a primary goal

Helping members cope with regulations affecting their practices is a primary goal of MSMS practice management programs. Members needing information and help to comply with the new OSHA bloodborne pathogen regulation, for example, will find assistance through several MSMS resources. The May issue of *Michigan Medicine* was entirely devoted to the new regulation and includes a mock audit of one physician's compliance. Members may choose to attend one of six seminars offered throughout the state, beginning this month. To underscore the importance of compliance with the new regulation, MPMLC-insured physicians attending one of the seminars are eligible for a two percent reduction in their professional liability insurance premiums.

One important aspect of the new OSHA regulation is the requirement that physicians

provide a free hepatitis B vaccine to employees exposed to bloodborne diseases. To assist members in complying with the regulation, MSMS has negotiated a discounted price of \$39.99 per vial from Bond Wholesale Pharmaceutical and Medical Supply.

Recent efforts to help members face new challenges like OSHA regulations and Medicare payment reforms supplement our ongoing efforts to help physicians with the daily challenges of practice. The MSMS subsidiary, Physician Service Group, Inc. (PSG), endorses a variety of services, some offering discounted rates to MSMS members. Members can find help with billing, collections, magazine subscriptions, office design services and other areas through PSG's endorsement program. It takes valuable time to find the service that meets the needs of a physician practice, and PSG can take the time to carefully scrutinize each product or service recommended to members. PSG also administers the MSMS-sponsored health insurance programs offered to members and their office staff.

Studies of health care spending suggest that anywhere from 20 to 40 percent of health care dollars are spent on administration. In a physician practice, these administrative dollars are being spent largely on keeping up with ever-changing requirements for insurance billing. This year, physicians are struggling with implementation of a Resource-Based Relative Value Scale payment system for Medicare and Medicaid, new codes for reporting office visit services and new claims forms for Medicare. Doing business with multiple insurers means keeping up with a variety of different regulations affecting reporting and payment of claims.

New MSMS service targets billing, coding practices

This year, MSMS began offering a new service to assist members with their billing and coding practices. MSMS staff is available for full- or half-day consultations with physicians and their office staff. Consultations are tailored to meet the needs of the individual physician, but generally include advice on proper documentation, minimizing rejections and maximizing payment. Members interested in the consultation service may contact Joyce Nurenberg at MSMS for more information.

More billing help will be available this fall, when MSMS will launch its New Biller Training Program. Designed for new billers or billers with limited experience, the training will be conducted by staff from Medical Management Systems of Michigan, a billing and reimbursement consulting firm. Five two- to three-day programs offered over five months beginning in October will cover billing basics, and offer specific information on billing Medicare, Medicaid, Blue Cross Blue Shield of Michigan and other payers. Billers may attend one or all five sessions. Watch for details in coming issues of *Michigan Medicine* and *Medigram*, or contact Mary Anne Ford at MSMS for more information.

Another new program under development is an orientation for new medical office staff. Covering telephone techniques, billing, medical terminology, medical record requirements, patient communication, scheduling and teamwork; the program will introduce your new office staff to MSMS services and resources and emphasize their importance in promoting a positive image for your practice. Again, details will follow in coming issues of *Michigan Medicine* and *Medigram*. ■

Mary Anne Ford is manager of the MSMS Department of Medical Economics and Health Care Delivery.

Physician Service Group endorsed services at a glance

Bell Atlantic-TriCon - medical equipment leasing program.

Cellular One - mobile telephone equipment and service.

IC System, Inc. - billing collection; **Medicollect** - an on-line collection service.

Medical Billing Service, Inc. - complete on-line computerization billing program.

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Physician Service Group administers and markets the MSMS group health insurance benefit program offering:

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Delta Dental Group Insurance Plan

Association Administrative Services - PSG provides administrative services to 14 specialty and allied organizations.

For more information contact Dawn Reha at (517) 336-7589.

Practice Management Quiz

Do you know the answers to these important questions?

Indeed, the practice of medicine is becoming more and more complex. From the new Medicare payment system to safe harbor and OSHA regulations, physicians are being bombarded with new and ever-changing challenges. If you think you know everything you need to about the many practice management issues now facing physicians, or if you're not quite sure, take a moment to answer the following questions. If you find out you didn't know as much as you thought, refer to the end of this quiz for some helpful information.

Match the following numbers with their corresponding description:

- 1. PIN number**
- 2. Common Provider Code**
- 3. UPIN**
- 4. PPI Number**
 - a. Number that is used by Medicare as a tracking mechanism for physicians who are ordering and referring services.
 - b. Payment number used by Medicare and BCBSM.
 - c. Number used by Medicare that identifies a specific performing physician in a group practice.
 - d. A single number representing two or more physicians of the same specialty in a group practice.
- 5. A patient is to have surgery and a routine x-ray is ordered. There were no prior or present symptoms or illness. The results of the x-ray reveal an abnormality. Do you:**
 - a. Bill Medicare for the x-ray since it showed a problem.
 - b. Bill the patient because it was routine.
- 6. True or false: The modifier-22 (unusual services) is the only modifier that can result in greater level of payment and is used by both Medicare and BCBSM.**
- 7. An accurate diagnosis on a claim affects:**
 - a. How much you will be paid.
 - b. Whether you will be paid at all.
- 8. You review the procedures and codes that you do in your office:**
 - a. Every year.
 - b. Every two years.
 - c. I cannot remember the last time.
- 9. Do you choose the level of care by the amount of time spent with a patient?**
 - a. Yes
 - b. No, I determine the level of care by evaluating the level of history, exam and medical decision-making performed.
 - c. Sometimes, in instances when counseling is greater than 50 percent of the total face-to-face time spent with the patient.
- 10. You or your office staff has a billing problem that you cannot seem to resolve, even though you feel that an error has been committed. Your next step should be:**
 - a. Write the money off.
 - b. Bill the patient.
 - c. Contact the MSMS Reimbursement Ombudsman at (517) 336-5722 for assistance.
- 11. Under the new OSHA bloodborne pathogens standard you must either red bag or label the following items:**
 - a. Containers of regulated waste.
 - b. Refrigerators/freezers containing blood.
 - c. Potentially infectious materials.
 - d. Containers used to store, transport or ship potentially infectious materials.
 - e. All of the above.
- 12. The new OSHA bloodborne pathogens standard requires you to do the following:**
 - a. Provide the Hepatitis B vaccination to *all* employees, including maintenance staff and billing clerks.
 - b. Wear personal protective equipment while doing any medical procedure.
 - c. Wash hands as soon as feasible following contact with blood or potentially infectious material.

- d. Use only disposable needles and sharps.
- e. Hire infectious disease consultants to train your staff on workplace safety.

13. There is a system within my office to *ensure* that for each diagnostic study I order for a patient:

- Y N** The study is conducted.
- Y N** The report is received in my office.
- Y N** The report is reviewed by an appropriate individual.
- Y N** The patient is notified of the results.
- Y N** The patient returns for additional studies/treatment as necessary.

14. Yes or no: All conversations with patients, occurring in or out of the office, which include *any* treatment advice are documented in the patient's record.

15. Yes or no: If involved in a malpractice claim or suit, I am confident my medical record would thoroughly support that I did not breach the standard of care, and would provide evidence useful for claiming comparative negligence.

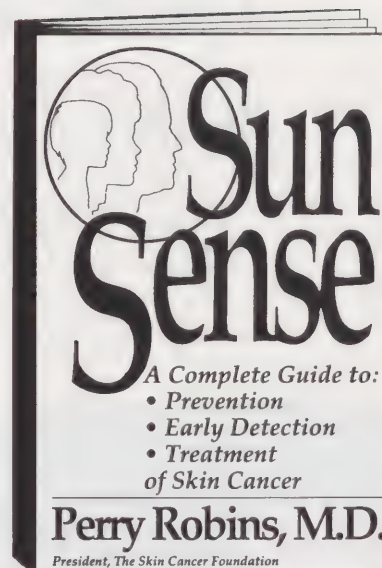
ANSWERS:

1. b; 2. d; 3. a; 4. c; 5. b; 6. true; 7. b; 8. a; 9. b or c; 10. c; 11. e; 12. c; 13. all yes; 14. yes; 15. yes.

Some helpful information

If you and your staff cannot answer the questions on this quiz, your next step should be:

- ✓ Attend one or more of the 70-plus practice management seminars offered each year by MSMS.
- ✓ Contact MSMS to arrange for a consultation on billing, coding or risk management practices in your office.
- ✓ Regularly read *Michigan Medicine* and *Medigram* for the latest information on OSHA, Medicare payment reform and other regulatory changes that affect your practice.
- ✓ Learn more about services endorsed by the MSMS subsidiary, Physician Service Group, Inc., that can help you with billing, collections and other important areas that are essential to keep your practice running smoothly.
- ✓ Attend a Risk Management Closed Claim Review Session sponsored by MSMS and MPMLC, and earn premium reductions for your medical liability insurance.
- ✓ *All of the above.*



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Medical Billing Service links the Blues to providers

This DENIS no menace

By Ralph D. Ward



The Blue Cross Blue Shield of Michigan Provider Inquiry Department usually represents two things to the billing staff at state medical practices. BCBSM is a vital resource for needed information on patient coverages, contract stipulations and payment and service codes. However, as the Blues discovered in a provider survey last year, they also represent a maddening dead-end of busy signals, telephone tag, long waits, and often incorrect information. To correct the situation the Michigan State Medical Society suggested the Blues work with Medical Billing Service (MBS), its endorsed on-line computer system.

There was "significant dissatisfaction with BCBSM Provider Inquiry Department service," according to Gary D. Maynard, MD, chairman of the BCBSM/MSMS liaison committee. MSMS users often spent 10 minutes waiting

on hold with inquiries, and only a lucky 10 percent of callers even got through on the first try. Although BCBSM had an advanced computer database of the needed information, the human links between the mainframes and the physician's office were holding up the entire process.

BCBSM recognized and attempted to correct the problem by developing the DENIS (Dial-in Eligibility Network and Information System) system. They found, however, its availability limited. BCBSM, after reviewing the situation, worked successfully with MBS to develop a potential answer to the data gridlock problem.

In 1991, BCBSM instituted the DENIS system to meet these needs with new technology. DENIS was designed by BCBSM to allow professional health care providers, DMEs, labs, etc., access to verify patients' coverage directly

by computer. This system complements the Blues' Provider Inquiry Department and the CAREN system.

Fine, as far as it goes, but DENIS remains available only on a limited basis. Currently 250 provider sites are utilizing the system, but these won't go far among the state's thousands of health care providers. Also, providers who wish to log on to the system need a dial-up modem and software, and must use a fairly complex procedure to get to the data they need.

MBS was aware of the problems its providers faced in gaining BCBSM data. "Our clients just couldn't get through," says MBS National Sales Manager Tom Thomas. "They were even resorting to 'busy buster' devices that automatically dial and redial a number." The MBS staff studied the problem, and, after the DENIS system came on-line, developed a solution. MBS' own on-line computer system was already in place, offering a broad-based network to over 3,200 physicians in Michigan (as well as 35 hospitals). "It was suggested that instead of trying to connect DENIS to every provider in the state, why not establish a link between the MBS system and DENIS? This would effectively connect more than 3,200 physicians to the BCBSM DENIS system at no additional cost to our clients."

The advantages of greater accuracy, speed and customer satisfaction seemed unbeatable, so tentative approval was given by the Blues. An advanced linkage system was built and financed by MBS and, starting in January, the system was launched with a pilot project which allowed 30 providers to use the system.

All parties concerned felt that the system would be easy to use and

committed to the training necessary for utilization. The current trial users (all of whom are also BCBSM participating physicians) received a careful orientation with DENIS from BCBSM. MBS representatives then made an on-site training visit to ori-

"Users can easily jump between DENIS and other MBS options, so reviewing a patient's BCBSM coverage codes takes less time than just dialing the number under the old system."

ent the provider, which usually requires less than an hour.

System easy to use

This simplicity extends to the actual use of DENIS. According to MBS Customer Support Manager, Susan Bentley, "Our users are already utilizing the system, so all they have to do is log on with two characters, 'BL' (Blue Link) and they're on in seconds. Then an inquiry takes about 30 seconds." Users can easily jump between DENIS and other MBS options, so reviewing a patient's BCBSM coverage codes takes less time than just dialing the number under the old system.

Even with only a few months experience, and only a handful of providers, results have been spectacular. "Although there are only 30 clients in the DENIS pilot program, there have been over 6,000 inquiries per month," observes Thomas. Bentley credits ease of use with the system's popularity. "With this linkage, there's a minimum of human intervention."

Clients echo this praise of the DENIS system. Eddy Wilcox, Office Manager at Ingham Radiology, PC, in Lansing, says, "This has really been helpful. We had to call BCBSM up to 70 times a week before. DENIS is comprehensive." Wilcox finds the system surprisingly friendly. "What I like best is that they include a 'wish list' options menu so we can suggest system enhancements for down the road. This is the greatest thing since sliced bread."

Further west, at Dudley & Associates, PC, in Grand Rapids, Office Manager Monna Essenberg finds the MBS/DENIS system ideally suited to their large, six-physician practice. "It's worked real well with our large volume of patients. We were on the phone almost constantly, but now a check takes only a few seconds." With the practice's steady flow of patients, this speed proves very handy. "So often the patient thinks they're covered for everything, but with DENIS you can check in on their coverage while they're still standing there."

The future seems bright for the BCBSM/MBS linkage. MBS looks forward to working with BCBSM to develop and expand beyond this pilot program to its entire client base. ■

Ralph Ward is a Lansing-based freelance writer.



EDUCATE

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- **Better Collections and Patient Flow Techniques**, Sept. 15-17, Flint, Williamston & Kalamazoo, and
- **Coding Institute**, offered in several locations this fall

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MICHIGAN STATE MEDICAL SOCIETY

EDUCATE

1992

SEMINARS & CONFERENCES

UPDATED CALENDAR

This is your 1992 Calendar of educational seminars and conferences sponsored by the Michigan State Medical Society. It has been updated to include new programs developed to meet your needs in 1992. Keep it in a convenient place for easy reference throughout the rest of the year.

REGISTRATION INFORMATION

You will receive a seminar brochure approximately six weeks prior to each seminar. It will include specific information on the course content and speakers, seminar locations and times, and appropriate registration fees. You can register by mail, telephone or FAX. Payment is accepted by check or Visa/Mastercard.

If you have questions regarding any of the seminars or registration, you can contact the MSMS Office of Physician Education at (517) 336-5784; FAX (517) 336-5797.

WE'LL SAVE YOU A SEAT - NO OBLIGATION!

Some seminars and locations have limited attendance and may fill quickly. You can submit an Early Registration Card or call the Office of Physician Education to indicate your interest in any of the seminars and conferences included on this calendar. We will hold you a seat! You will be billed for the seminar only after you have received the complete seminar brochure and have confirmed your plans to attend.

ADDITIONAL WORKSHOPS AND SEMINARS

We will continue to develop new seminars and conferences to meet your ever-changing needs. Let us know what areas of interest you have, and then watch for updated calendars and announcements in MSMS publications Medigram and Michigan Medicine.

TAX DEDUCTIBLE

These seminars permit a tax deduction for educational expenses including registration fees, travel, meals and lodging.

TO BE ADDED TO OUR MAILING LIST

MSMS Educational mailings are sent to all member physicians and to previous seminar or conference participants. If you would like to be added to our mailing list, please send your name and address on an Early Registration Card, or call the Office of Physician Education at (517) 336-5784.

Other organization mailing lists are often used when their members will benefit from a particular seminar or conference. If your name is on several lists and you are receiving duplicate seminar mailings, please forward a copy to a colleague who will benefit from MSMS's educational programs.

For more information on Practice Management or Risk Management Seminars, MSMS Conferences, or Category I CME opportunities, contact the Office of Physician Education, 120 W. Saginaw, East Lansing, Michigan 48823, or call (517) 336-5784; FAX (517) 336-5797.



MSMS 1992 CALENDAR

SEMINARS AND CONFERENCES

SUMMER & FALL UPDATE

JULY

How to Comply with MIOSHA Regulations

July 22 - Novi Hilton, Novi

July 29 - Grand Traverse Resort, Traverse City

AUGUST

How to Comply with MIOSHA Regulations

August 18 - Novi Hilton, Novi

Medical Office Management Institute

August 18, 19, 20 & 21 - Grand Traverse Resort,
Traverse City

Health Education Foundation Family Outing

August 20 - 23 - Sylvan Treetops Resort, Gaylord

SEPTEMBER

How to Comply With MIOSHA Regulations

Sept. 8 - Wayne County Medical Society, Detroit

Sept. 10 - WMU Regional Center, Grand Rapids

Sept. 14 - Treasure Island, Saginaw

**Better Collections, Billing and Insurance Methods and
Reception and Patient Flow Techniques**

Sept. 15 - Flint Holiday Inn, Flint

Sept. 16 - Brookshire Inn, Williamston

Sept. 17 - Fetzer Center, Kalamazoo

Management & Marketing For the Medical Practice

Sept. 18, 19, & 20 - Grand Hotel, Mackinac Island

Coding Institute

Sept. 22, 23, & 24 - Bay Valley Resort, Bay City

Health Law Update

Sept. 30 - Brookshire Inn, Williamston

OCTOBER

Risk Management/Closed Claim Reviews (Pediatrics)

Oct. 5 - MSMS Headquarters, East Lansing

Oct. 8 - WMU Regional Center, Grand Rapids

**Women Physician's Professional Development Conference
"Sexual Harassment in the Medical Workplace"**

Oct. 9 & 10 - Radisson Hotel, Kalamazoo

Coding Institute

Oct. 13, 14, & 15 - WMU Regional Center, Grand Rapids

Oct. 20, 21, & 22 - Hotel Baronette, Novi

Medicare Update

Oct. 27 - WMU Regional Center, Grand Rapids

Oct. 28 - Brookshire Inn, Williamston

Oct. 29 - Hotel Baronette, Novi

NOVEMBER

Risk Management/Closed Claim Reviews (Pediatrics)

Nov. 3 - Novi Hilton

Nov. 11 - Treasure Island, Saginaw

Risk Management/Practice Parameters

Nov. 5 - Novi Hilton, Novi

Nov. 10 - WMU Regional Center, Grand Rapids

Nov. 12 - Brookshire Inn, Williamston

AIDS Speakers' Bureau Update

November 16 - Hyatt Regency, Dearborn

"A Conversation With Ann Jillian"

November 17 - Hyatt Regency, Dearborn

MSMS/AMA Medical Office Staff Series

November 17, 18, 19, 20 - Hyatt Regency, Dearborn

MSMS Annual Scientific Meeting

November 17, 18, & 19 - Hyatt Regency, Dearborn

HOW TO COMPLY WITH MIOSHA REGULATIONS

July 22, 29, August 18

September 8, 10, 14

Novi, Traverse City, Marquette

Detroit, Grand Rapids, Saginaw

This all day seminar will provide you with current information regarding MIOSHA compliance and reporting requirements for physician offices, special requirements regarding bloodborne pathogens, information on complying with and educating your employees regarding Right to Know/Hazard Communications, and guidelines for the proper disposal of medical waste.

MEDICAL OFFICE MANAGEMENT INSTITUTE

August 18, 19, 20, 21

Traverse City

A four-day series of in-depth programs designed for medical office managers, supervisors, and office staff. Each day will cover a separate program on personnel management, patient flow management, financial management and collections. Participate in one or all four sessions to be presented by Conomikes Associates, Inc.

HEALTH EDUCATION FOUNDATION FAMILY OUTING

August 20, 21, 22, 23

Gaylord

This first annual event will provide many opportunities for golf, tennis, hiking, canoeing and other events for families, couples and singles alike. An automobile prize for the Hole-in-One Contest and children's programming are planned. Proceeds will benefit the Health Education Foundation. Contact: Dawn Reha, Executive Secretary, HEF, (517) 336-7589.

BETTER COLLECTIONS, BILLING AND INSURANCE METHODS

September 15, 16, 17

Flint, Williamston, Kalamazoo

This morning course will help the new employee gain more knowledge about effective collection practices, billing techniques and insurance processing to improve performance and profitability. It will also serve as a good "refresher course" for the longer term employee.

RECEPTION AND PATIENT FLOW TECHNIQUES

September 15, 16, 17

Flint, Williamston, Kalamazoo

Attend this afternoon course for the front office staff. Learn how to take control of appointment scheduling, improve office telephone skills and procedures, and maintain good medical records.

MANAGEMENT & MARKETING FOR THE MEDICAL PRACTICE

September 18 - 20

Mackinac Island

Several professional speakers will present information to Manage an Efficient and Patient-Service Oriented Medical Practice, Transform Your Staff into a Winning Team, and Develop Internal & External Marketing Tools That Work. Plan to attend this weekend seminar for physicians, office managers and their families, held in a casual, resort atmosphere.

CODING INSTITUTE

September 20-24

October 13-15,

Oct. 20 - 22

Bay City

Grand Rapids

Novi

- How To Improve Your CPT-4 and HCPCS Procedure Coding (Day One)
- More Effective ICD-9-CM Diagnosis Coding (Day Two)
- Fee and Claims Analysis Techniques (Day Three)

Receive up-dated information that you can use immediately to ensure the highest reimbursements possible. Attend one, two or all three days of the Coding Institute, to be presented by Conomikes Associates, Inc.

HEALTH LAW UPDATE

September 30

Williamston

A valuable course to provide physicians and their office managers with information on medical legal issues, to be presented by Kerr, Russell & Weber, Attorneys and Counselors for MSMS. Specific topics covered will include the most current issues affecting physicians and their practice.

RISK MANAGEMENT/CLOSED CLAIM REVIEW SESSIONS (PEDIATRICS)

October 5, 8

East Lansing, Grand Rapids

November 3, 11

Novi, Saginaw

Closed Claim Review Sessions are round-table discussions of actual closed Michigan malpractice cases. They are specialty-specific and structured to encourage group participation, exploring issues surrounding the cases and possible preventive measures. Merit rating credits and 3 hours of Category I CME credit are available. Contact Julie Smith at MSMS, (517) 337-1351.

WOMEN PHYSICIAN'S PROFESSIONAL DEVELOPMENT CONFERENCE "SEXUAL HARASSMENT IN THE MEDICAL WORKPLACE"

October 9 & 10

Kalamazoo

This program will provide women physicians with an opportunity to meet with other's from around the state, as they explore sexual harassment issues from a preventive, non-threatening perspective. The conference will offer communication skills training and guidelines for establishing sexual harassment prevention and grievance procedures. Contact: Lori Randall, Chief, Physician Education, (517) 336-5728.

MEDICARE UPDATE

October 27, 28, 29

Grand Rapids, Williamston, Novi

A timely workshop on Medicare management that is taught by Conomikes Associates, Inc. This seminar will help you get your Medicare program on track and keep it on track despite all the recent changes in Medicare rules.

RISK MANAGEMENT/PRACTICE PARAMETERS

November 5, 10, 12

Novi, Grand Rapids, Williamston

Practice guidelines have the potential to reduce the number of malpractice cases and cost of settling them. Attend this new series of Risk Management programs to learn how you can be involved in the development and dissemination of appropriate parameters which will aid, not hinder the medical practice. Contact: Julie Smith, Chief, Risk Management, (517) 337-1351.

AIDS SPEAKER'S BUREAU UPDATE

November 16

Dearborn

This program will provide an update on legislative, clinical and other public policy issues related to HIV/AIDS, as well as provide current information regarding the MSMS HIV/AIDS Speaker's Bureau. Contact: Tracy Baker, Coordinator, AIDS Provider Education Project, (517) 336-5770.

"A CONVERSATION WITH ANN JILLIAN"

November 17

Dearborn

Come hear Ann Jillian, and her husband Andy Murcia, speak about the hopeful side of breast cancer in an entertaining and humorous fashion as only she can. They will share their life experiences including the recent birth of their son, at this dinner event held during the MSMS Annual Scientific Meeting.

MSMS/AMA OFFICE STAFF TRAINING SERIES

November 17, 18, 19, 20

Dearborn

An opportunity for the medical office staff to get years of practical experience about Insurance Processing and Coding, The Business Side of Medicine, Advanced CPT-4, ICD-9-Coding and Medical Collections in four days of in-depth training. Includes admission to Exhibit Hall at MSMS Annual Scientific Meeting.

MSMS ANNUAL SCIENTIFIC MEETING

November 17, 18, 19

Dearborn

Attendees can choose from over 50 courses to learn the latest information on a variety of medical topics. An extensive exhibitors display, specialty and social functions complement the educational sessions. Up to 20 hours of Category I



**For further information, Call the
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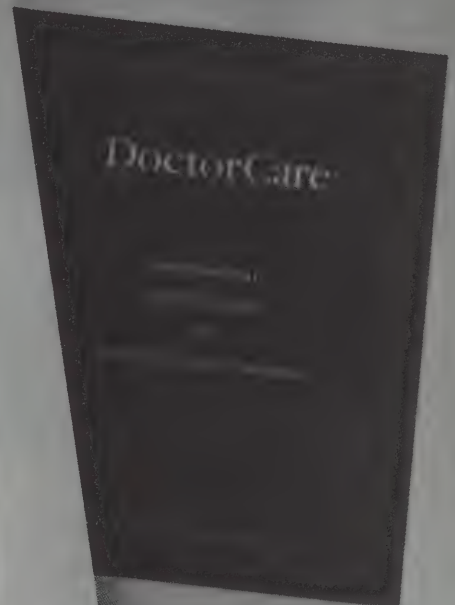
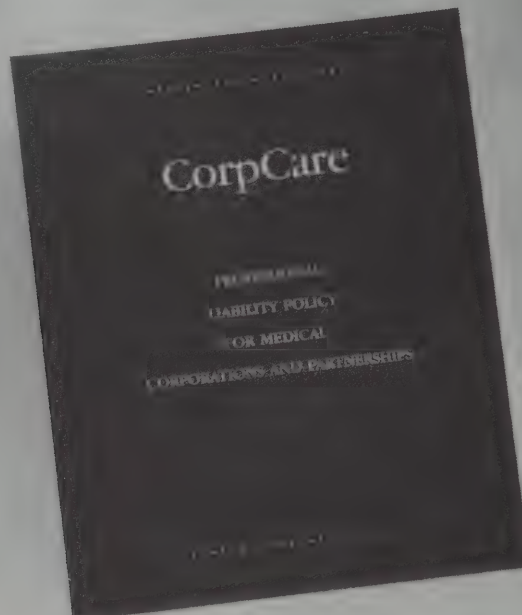
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Lyme Disease in Michigan

AN UPDATE

By Mary Grace Stobierski, DVM, MPH,
Sally A. Bidol, MPD, and William N. Hall,
MD, MPH, *Disease Surveillance Section/
Michigan Department of Public Health*



Michigan's first reported human case of Lyme disease occurred in 1985. Since then, a total of 492 Michigan residents have been reported with illness fitting the Centers for Disease Control (CDC) case definition. The 1985 case definition was used until January 1991, when the state began using the more specific 1990 version. Reporting was voluntary until the spring of 1990, when it became mandatory by emergency rule. The annual number of reported cases reached a peak in 1989 with 174 cases, and has since decreased, with 136 cases in 1990 and 34 cases reported in 1991.

Initially, the reported cases were from the western upper peninsula region of the state. In Menominee county, located in Michigan's upper peninsula, *Ixodes dammini*, the known vector in Michigan, which is the deer tick, has been collected in high numbers. Also, *Borrelia burgdorferi*, the causative agent, has been identified both in *Peromyscus leucopus* (the white-footed mouse) and deer ticks found there. This area has the highest rate of Lyme disease cases in people in the state.

Suspect cases were identified from several counties in the lower peninsula in 1988. These individuals had not reported any travel to areas known to be endemic for Lyme disease (1,2,3), thus the most likely place of exposure was deemed to be in the lower peninsula. A stimulated surveillance program, for acute cases of Lyme disease, instituted in 1990, had failed to identify any environmental focus of the disease in the lower peninsula, however.

Since the vector tick has been found in the lower peninsula only on rare occasions, and because no infected ticks or rodents have ever been found in the lower peninsula, an Active Surveillance Program was begun to evaluate reported acute cases of Lyme disease and thoroughly investigate likely exposure sites in the lower peninsula.

The goals of the Active Surveillance Program were to:

1. Determine if acute Lyme disease occurs in lower peninsula Michigan.
2. Identify and collect descriptive epidemiological and ecological information on all patients with acute Lyme disease in Michigan's lower peninsula.

Methods

The 1991 Active Surveillance Program for Lyme disease was implemented during a 10-week period beginning July 12, 1991 and ending September 30, 1991.

For purposes of this surveillance system we defined acute Lyme disease cases as individuals exhibiting physician-observed erythema migrans (EM) of 5 cm in diameter or larger.

Surveillance sites for the Active Lyme Disease Surveillance Project were selected based upon the following criteria: any lower peninsula county in which a patient, likely to have acute Lyme disease, was identified during the 1990 Lyme disease surveillance program, or any lower peninsula county in which the *Ixodes dammini* tick vector had been recovered. Accordingly, a 13-county study area (Clinton, Genesee, Ingham, Jackson, Kent, Lapeer, Livingston, Macomb, Manistee, Monroe, Oakland, Oceana, and Washtenaw) within Michigan's lower peninsula was targeted for the Active Lyme Disease Surveillance Program.

The Medical Directors of the local health departments serving the above-mentioned counties were contacted. They were asked to provide us with the names of physicians from their health jurisdiction who were most likely to see patients with acute Lyme disease. A total of 63 physician names were provided.

Enrollment of physicians into the surveillance network began the latter half of July and continued through a three-and-a-half week period into mid-August. An introductory letter was mailed to each potential physician contact to inform them about

the Active Lyme Disease Surveillance Project. This letter also requested their assistance with the surveillance project by identifying and reporting all individuals under their care with acute Lyme disease, which met the surveillance definitions.

Routine surveillance calls were made to each practitioner's office to collect surveillance information at two-week intervals.

At each surveillance contact, physician offices were asked to answer the following standard set of questions:

1. Had they identified any patients with acute Lyme disease during the most recent surveillance period?
2. If so, did the patient present with the erythema migrans rash typical of Lyme disease?
3. If so, what was the appearance and diameter of the observed rash?

All reports of Lyme disease that fit the surveillance definition received by the Disease Surveillance Section/MDPH through either the Active Surveillance Network or the routine passive surveillance system were followed-up. If the patient did fit the case definition for acute Lyme disease with an exposure in Michigan, the information was provided to the Bureau of Environmental & Occupational Health/MDPH for ecological follow-up.

Results

All 28 offices were contacted at two week intervals throughout the study period beginning July 15 through September 30, 1991. No acute cases of Lyme disease were reported through the Active Surveillance System during the surveillance period.

One case was reported through the routine passive surveillance system for Lyme disease. The case was reported the week of 9/8/91.

This case involved a 69-year-old white woman residing in Oakland County with a physician-diagnosed EM compatible rash on her left hip, measuring 5 x 6 cm in diameter. A complete field interview was performed and a serum sample was collected for antibody testing. Results of IgM and IgG ELISA tests were negative, and Western Blot results were also negative. Environmental sampling was recom-

“Our surveillance findings were consistent with the hypothesis that very little Lyme disease occurs in lower peninsula Michigan.”

mended at the sites of likely exposure, in Iosco County. This field sampling was completed in mid-October. No *Ixodes dammini* ticks were identified; rodent ear-biopsy results (for *Borrelia burgdorferi* culture) are negative.

Discussion

Our surveillance findings were consistent with the hypothesis that very little Lyme disease occurs in lower peninsula Michigan. These results support the findings of earlier Michigan Lyme disease surveillance efforts that also found few cases of acute Lyme disease with EM in lower peninsula Michigan. The result of this surveillance project agrees with informal reports that Michigan practitioners are not seeing large numbers of Lyme disease cases.

If the surveillance area in Michigan was expanded to include areas in the upper peninsula where presence of infected *Ixodes dammini* and *Peromyscus leucopus* (white-footed

mice) have been verified (Menominee county), the cases found there could be clinically described. This would provide us with information that would be useful in comparing the clinical presentation of Michigan patients, to patients from other areas of the country. Thus it would provide us with a means for characterizing Lyme disease in Michigan residents.

Federal funding for this program was not approved until mid-June 1991; the start-up date was delayed until mid-July. This was a clear deficiency in our Active Surveillance Program. Increased tick activity in Michigan usually occurs in April, so acute Lyme cases that occurred early in the 1991 season were not included. This start date was well into the typical “Lyme disease season” in Michigan, and as such, may have missed the period when acute Lyme disease is most likely to occur.

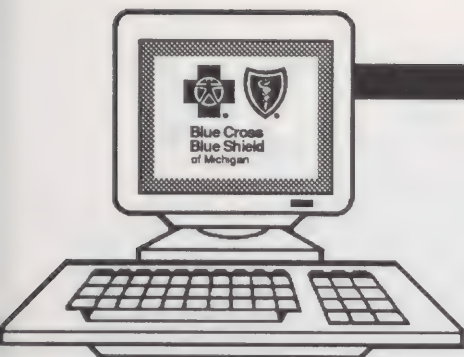
The late start-up also affected the implementation of this study. Under the accelerated timetable of this program, local health departments had to respond quickly to our request for names of prospective physician contacts. Similarly, little time was available to enlist prospective physicians into the active surveillance network.

Because of these shortcomings, the results of this study should be interpreted with some caution.

Recommendations

1. Active surveillance should be implemented earlier in the season, to coincide with more likely exposure periods in Michigan.

2. This program should be expanded to include areas in the upper peninsula (Menominee County) where presence of infected *Ixodes dammini* and *Peromyscus leucopus* have been verified. This will allow clinical characterization of the cases found in our state. ■



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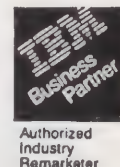
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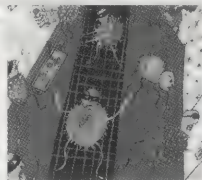
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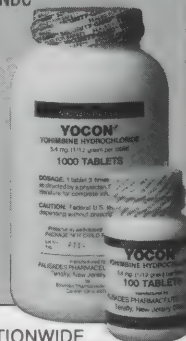
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1. A. Morales et al., *New England Journal of Medicine*: 1221, November 12, 1981.
2. Goodman, Gilman — *The Pharmacological basis of Therapeutics* 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. *Weekly Urological Clinical letter*, 27:2, July 4, 1983.
4. A. Morales et al., *The Journal of Urology* 128: 45-47, 1982.

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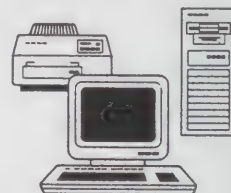
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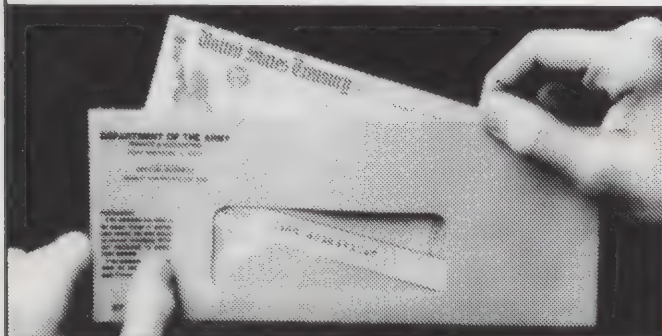
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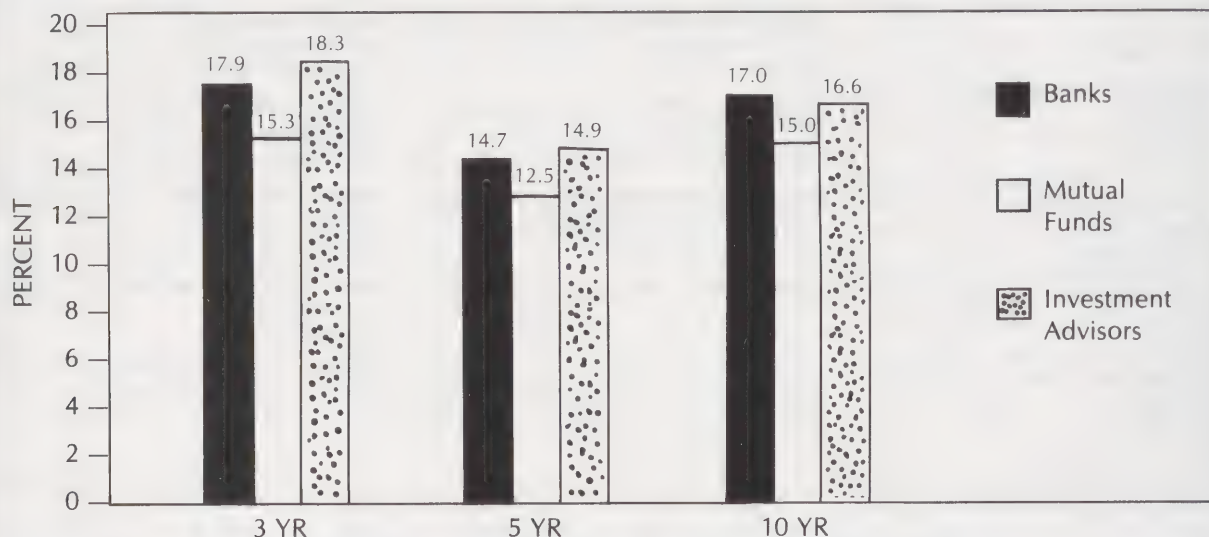
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Coconut Creek, FL

Matthew A. Balcerski, MD, an internist, died February 2, 1992. He was 86. A 1932 graduate of the Wayne State University School of Medicine, Doctor Balcerski was affiliated with Detroit Receiving Hospital. He was a member of the Wayne County Medical Society and MSMS.

Mark Dale, MD

Farmington Hills

Mark Dale, MD, an internist, died January 5, 1992. He was 75. A 1941 graduate of Wayne State University School of Medicine, Doctor Dale was affiliated with William Beaumont Hospital, Royal Oak, and Highland Park General Hospital, Highland Park. He was a member of the Wayne County Medical Society and MSMS.

Alfred E. Eyres, MD

Grosse Pointe Park

Alfred E. Eyres, MD, a psychiatrist, died March 17, 1992. He was 84. A 1932 graduate of University of Iowa Medical School, Doctor Eyres was affiliated with Jennings Memorial, Grace, and St. Clair hospitals. He was a member of the Michigan Society of Neurology and Psychiatry, the Wayne County Medical Society and MSMS.

Francis G. Garrett, MD

Clarkston

Francis G. Garrett, MD, a thoracic surgeon, died January 26, 1992. He was 72. A 1944 graduate of the University of Buffalo Medical School, Doctor Garrett was affiliated with Harper and Children's hospitals, Detroit, and St. Joseph's Hospital of

Mt. Clemens.

He was a member of the American Association of Thoracic Surgeons, Society of Thoracic Surgeons, American College of Surgeons, Macomb County Medical Society and MSMS.

Robert L. Kamm, MD

Birmingham

Robert L. Kamm, MD, a psychiatrist, died January 27, 1992. He was 72. A 1960 graduate of Western Reserve Medical, Cleveland, Ohio, Doctor Kamm was affiliated with Receiving Hospital, Detroit. He was a member of the American Psychiatric Association, Oakland County Medical Society and MSMS.

Continued on page 53

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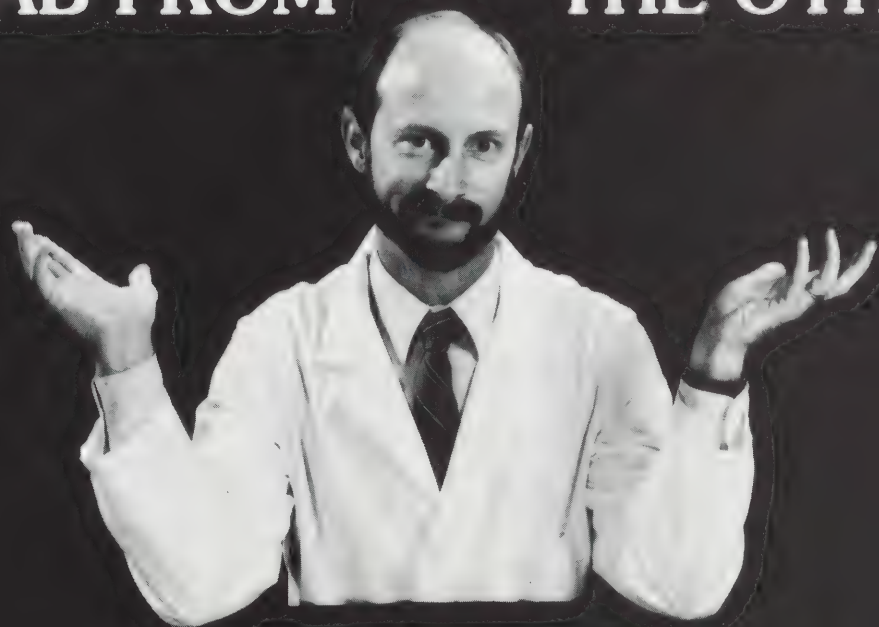
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OBITUARIES

Continued from page 51

Daniela A. Kollar, MD

Troy

Daniela A. Kollar, MD, a neurologist, died December 11, 1991. She was 36. A 1983 graduate of the Wayne State University School of Medicine, Doctor Kollar was affiliated with Harper Hospital, Detroit. She was a member of the American Medical Association, Oakland County Medical Society and MSMS.

Charles W. Newton, MD

Ann Arbor

Charles W. Newton, MD, an obstetrician and gynecologist, died March 11, 1992. He was 78. A 1940 graduate of the University of Michigan Medical School, Doctor Newton was affiliated with St. Joseph Mercy Hospital, Ann Arbor. He was a member of the Central Society of Obstetricians and Gynecologists, Ameri-

can College of Surgeons, the American College of Obstetricians and Gynecologists, the Washtenaw County Medical Society and MSMS.

Charles W. Oakes, MD

Bradenton, FL

Charles W. Oakes, MD, a general surgeon, died February 16, 1992. He was 91. A 1926 graduate of the University of Nebraska Medical School, Doctor Oakes was founder of The Oakes Clinic in Harbor Beach, now the Henry Ford Hospital Oakes Center. He was a former president of the Huron County Medical Society, and former member of the American Academy of Family Practice, the Huron County Medical Society and MSMS.

Addison E. Prince, MD

Detroit

Addison E. Prince, MD, an obstetrician and gynecologist, died Feb-

ruary 20, 1992. He was 75. A 1944 graduate of the Wayne State University School of Medicine, Doctor Prince was affiliated with Burton Mercy, Detroit Memorial, Harper, and Womens hospitals, Detroit. He was a member of the American College of Obstetrics and Gynecology, the American College of Surgeons, the Detroit Surgical Society, the Wayne County Medical Society and MSMS.

Glenn A. Sanford, MD

Holly

Glenn A. Sanford, MD, an orthopedic surgeon, died February 8, 1992. He was 67. A 1949 graduate of New York University College of Medicine, Doctor Sanford was affiliated with Pontiac General and St. Joseph Mercy hospitals. He was a member of the Oakland County Medical Society and MSMS. ■

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MEETINGS

MSMS Meetings

July

16-19, MSMS Board of Directors Meeting, Grand Traverse Resort, Traverse City, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

22, 29, MSMS Practice Management Seminar "How to Comply with MIOSHA Regulations." July 22, Novi Hilton, Novi, MI; July 29, Grand Traverse Resort, Traverse City, MI. Contact: MSMS Office of Physician Education, (517) 336-5784.

August

18, MSMS Practice Management Seminar "How to Comply with MIOSHA Regulations." Holiday Inn, Marquette, MI. **Contact: MSMS Office of Physician Education, (517) 336-5784.**

18, 19, 20 & 21, MSMS Practice Management Seminar, "Medical Office Management Institute," by Conomikes Associates, Inc., Grand Traverse Resort, Traverse City, MI. Contact: Office of Physician Education, (517) 336-5784.

ciates, Inc., Grand Traverse Resort, Traverse City, MI. Contact: Office of Physician Education, (517) 336-5784.

20-23, Health Education Foundation "First Annual Family Outing." Sylvan Treetops Resort, Gaylord, MI. Contact: Dawn Reha, executive secretary, Health Education Foundation, (517) 336-7589.

September

8, 10, 14, MSMS Practice Management Seminar, "How to Comply with MIOSHA Regulations." Sept. 8, Wayne County Medical Society, Detroit, MI; Sept. 10 Western Michigan University Regional Center, Grand Rapids, MI; Sept. 14 Treasure Island, Saginaw, MI.

16, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

15, 16 & 17, MSMS Practice Management Seminar, "Better Collections, Billing and Insurance Methods" and "Re-

ception and Patient Flow Techniques," September 15, Flint Holiday Inn, Flint, MI; September 16, Brookshire Inn, Williamston, MI; September 17, Fetzner Center, Kalamazoo, MI. Contact: Office of Physician Education, (517) 336-5784.

18, 19, & 20, MSMS Practice Management Seminar, "Management & Marketing for the Medical Practice, Grand Hotel, Mackinac Island. Contact: Office of Physician Education, (517) 336-5784.

22, 23 & 24, MSMS Practice Management Seminar, "Coding Institute," by Conomikes Associates, Inc., Bay Valley Resort, Bay City, MI. Contact: Office of Physician Education, (517) 336-5784.

30, MSMS Practice Management Seminar, "Health Law Update," by Kerr, Russell & Weber, Brookshire Inn, Williamston, MI. Contact: Office of Physician Education, (517) 336-5784.

Continued on following page

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MEETINGS

October

5, 8, MSMS/MPMLC Risk Management/Closed Claim Review (Pediatrics) Oct. 5, MSMS Headquarters, East Lansing; Oct. 8 Western Michigan University Regional Center, Grand Rapids, MI. Contact: Julie Smith, chief, Risk Management. (517) 337-1351.

9, 10, Women Physicians Professional Development Conference "Sexual Harassment in the Medical Workplace." Radisson Hotel, Kalamazoo MI. Contact: Lori Randall, chief, Physician Education, (517) 336-5728.

13, 14 & 15, MSMS Practice Management Seminar, "Coding Institute," by Conomikes Associates, Inc., WMU Regional Center, Grand Rapids, MI. Contact: Office of Physician Education, (517) 336-5784.

20, 21 & 22, MSMS Practice Management Seminar, "Coding Institute," by Conomikes Associates, Inc., Hotel Baronette, Novi, MI. Contact: Office of Physician Education, (517) 336-5784.

27, 28, 29, MSMS Practice Management Seminar, "Medicare Update," by Conomikes Associates, Inc., October 27, WMU Regional Center, Grand Rapids, MI; October 28, Brookshire Inn, Williamston, MI, October 29, Hotel Baronette, Novi, MI. Contact: Office of Physician Education, (517) 336-5784.

November

3, 11, MSMS/MPMLC Risk Management "Closed Claim Review" (Pedi-

rics)" Nov. 3 Novi Hilton, Novi MI; Nov. 11 Treasure Island, Saginaw, MI. Contact: Julie Smith, chief, Risk Management, (517) 337-1351.

4, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

5, 10, 12, MSMS/MPMLC Risk Management "Practice Parameters." Nov. 5 Novi. Hilton, Novi, MI; Nov. 10, Western Michigan University Regional Center, Grand Rapids, MI; Nov. 12, Brookshire Inn, Williamston. Contact: Julie Smith (517) 337-1351.

16, MSMS AIDS Speakers' Bureau Update. Hyatt Regency, Dearborn, MI. Contact: Tracy Baker, Coordinator AIDS Provider Education Project, (517) 336-5770.

17, "A Conversation with Ann Jillian." Hyatt Regency, Dearborn, MI. Contact: Sarah Cressman, Assistant for Physician Education, (517) 336-5727.

17-19, MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 337-1351.

17, 18, 19, 20, MSMS/AMA Medical Office Staff Series, Hyatt Regency, Dearborn, MI. Contact: Office of Physician Education, (517) 336-5784.

AMA Meetings

July

6-9, American Orthopaedic Society of Sports Medicine, San Diego, CA. Contact: (708) 803-8700.

27-29, American Hospital Association, Denver, CO. Contact: (312) 280-6323.

August

8-14, Society of Magnetic Resonance in Medicine Scientific Meeting and Exhibition. Contact: Chairman, Young Investigator's Award Committee, Society of Magnetic Resonance in Medicine, 1918 University Avenue, Suite 3C, Berkeley, CA 94704, USA.

16-19, American Psychological Association, Washington, DC. Contact: (202) 955-7705.

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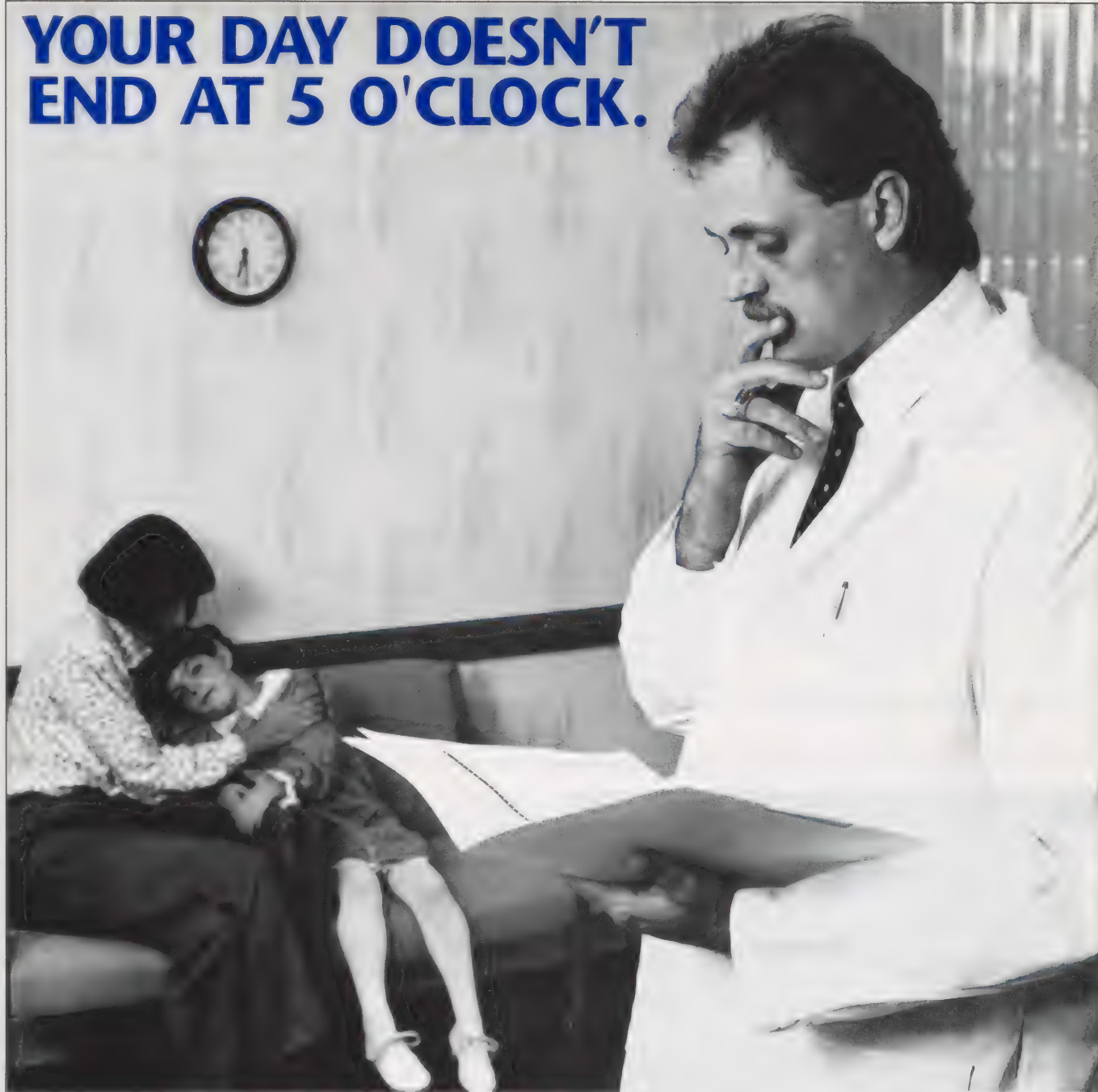
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

July

21, 28, Religion and Psychotherapy.

Location: Bar-Levav Educational Association, Southfield, Michigan. **Sponsors:** Bar-Levav Educational Association. **Contact:** David Fogel, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

23-26, Eighteenth Annual Mackinac

Island Course: Advances in the Management of Infectious Diseases. Location:

Grand Hotel, Mackinac Island, Michigan. **Sponsors:** University of Michigan. **Contact:** Edwina Borde, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 764-1422. **Approved for:** 13 hours Category I Credit.

24, Controversies in Spine Surgery. Location:

Ritz Carlton Hotel, Dearborn, Michigan. **Sponsors:** William Beaumont Hospital, Department of Orthopaedic Surgery. **Contact:** Ms. Liz Kretschmann, Continuing Medical Education Office, William Beaumont Hospital, 3601 West Thirteen Mile Rd., Royal Oak, MI 48073-6769, (313) 551-0429. **Approved for:** 7 hours Category I Credit.

24-25, General Psychiatry: A Family Perspective, Scientific Meeting. Location:

Grand Traverse Resort, Tra-

verse City Michigan. **Sponsors:** Michigan Psychiatric Society. **Contact:** Dodie Malloy, Michigan Psychiatric Society, 30100 Telegraph Rd., Suite 219, Birmingham, MI 48010, (313) 647-7600. **Approved for:** 8 hours Category I Credit.

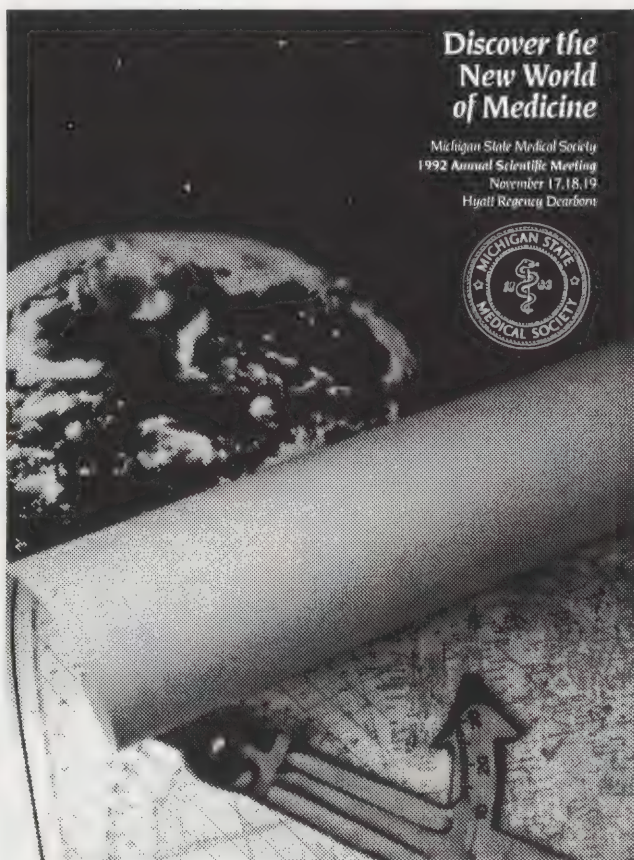
30-31, 72nd Annual Collier Penberthy Thirlby Medical Conference. Location:

Park Place Hotel, Traverse City, Michigan. **Sponsors:** Munson Medical Center and Medical Staff. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684, (616) 935-6546. **Approved for:** 9-13 hours Category I Credit.

August

3-6, Mackinac Island Imaging Conference. Location:

Grand Hotel, Mackinac Island, Michigan. **Sponsors:** William Beaumont Hospital-Diagnostic Radiology. **Contact:** Mary Anne Smith, Diagnostic Radiology, William Beau-



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mont Hospital, 3601 W. 13 Mile Rd., Royal Oak, MI 48073, (313) 551-6199. **Approved for:** 21 hours Category I Credit.

4, 11, 18, Focusing on Method: How to Repair the Boundaries of the Self.

Location: Bar-Levav Educational Association, Southfield, Michigan. **Sponsors:** Bar-Levav Association. **Contact:** David Fogel, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 6 hours Category I Credit.

10-12, Internal Medicine Update. Location:

Grand Hotel, Mackinac Island, Michigan. **Sponsors:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Edwina Borde, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 936-1678. **Approved for:** 12 hours Category I Credit.

20-23, Cardiology Update. Location: Grand Hotel, Mackinac Island, Michi-

gan. **Sponsors:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Edwina Borde, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 936-1678. **Approved for:** 12 hours Category I Credit.

25, The Effects of Emotional Illness on the Future of our Society. Location:

Bar-Levav Educational Association, Southfield, Michigan. **Sponsors:** Bar-Levav Association. **Contact:** Joseph Gluski, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 8 hours Category I Credit.

September

1, 8, 15, Self-Indulgence: A Conscious Resistance or Part of an Illness. Location:

Bar-Levav Association, Southfield, Michigan. **Sponsor:** Bar-Levav Association. **Contact:** David Fogel, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-

5333. **Approved for:** 6 hours Category I Credit.

15-17, Advances in CT and MRI. Location:

Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Department of Radiology. **Contact:** Edwina Borde, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 764-2651. **Approved for:** 17 hours Category I Credit.

16, Radiologic Technologist Program. Location:

Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Radiology. **Contact:** Edwina Borde, Registrar, Office of Continuing Medical Education, Towsley Center, P.O. Box 1157, University of Michigan Medical School, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 17 hours Category I Credit.

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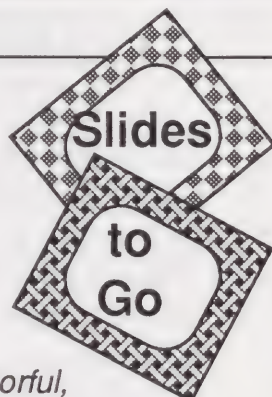
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Continued from page 64

Finally, the chiropractors argue that health care costs will be reduced under SB 305 because it will foster competition. But aren't chiropractors already free to compete under their current scope of practice? They say this bill simply levels the playing field. But if that's the case, may a physician then hang up his or her shingle after only six years of schooling after high school?

The problem for the legislature is that they want to let people do things they are trained for, but they don't always have all the facts to make a truly informed decision.

And all too often, decisions like this are driven by politics, and the facts don't have much to do with it.

So, there's one final question. "If we don't call or write to our state representatives today to oppose this legislation, who will?" ■

Doctor Payne is MSMS president.

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Expanding chiropractors' scope of practice not in the best interest of the public.

Physicians must convey this message to legislators

By Thomas C. Payne, MD

The question in the allied health fields these days seems to be "How do I treat more people and get reimbursed more for it?"

The answer seems to be another question. It is "How can I expand my scope of practice?" or "How can I become a physician without going through medical school, internship and residency?"

The *real* question these days, however, is "Will an expanded scope of practice for various groups really serve the public well?"

That's the question the Michigan legislature is grappling with right now with a bill to greatly expand the scope of practice for chiropractors — Senate Bill 305.

Much to the dismay of the Michigan State Medical Society, the Senate Health Policy Committee approved the bill by a vote of 3-1 on May 19. On May 28, the full Senate passed SB 305 by a vote of 22-14. The bill is now in the House Public Health Committee and probably will be acted on in September.

In the meantime, we need to answer an important question for our state representatives. The question is, "Will this bill really serve the public?"

The chiropractors argue that the bill will allow them to improve access to care, it will lower the cost of health care and it will improve quality.

But let's take a look at those issues.

When they say the bill will improve access to care, you have to define *what* care. And the access argument has to be tied to the quality argument.

The bill greatly expands the scope of practice to allow chiropractors to do physical examinations including "the taking of blood pressure and

pulse, and the use of a stethoscope, otoscope, thermometer and tongue depressor."

They also would be allowed "to perform physiotherapy measures including massage, mobilization, traction, heat, cold, air, light, electricity, therapeutic ultrasound and rehabilitation..."

In other words, the chiropractors are seeking to become primary care physicians.

Do chiropractors have the medical education and clinical training to do all of the above? Absolutely not.

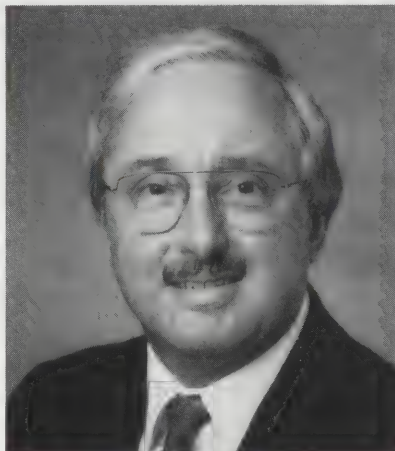
Performing a physical examination includes much more than merely listening to a person's heartbeat or checking the blood pressure. It takes a comprehensive and dynamic series of interactions with a patient that includes careful observation

combined with palpations and auscultation. The instruments a physician uses are an extension of his or her senses. It takes years of medical education and clinical training to attune oneself to the subtleties of certain disease processes, which may be discovered for the first time during a physical exam.

The same concerns are true about chiropractors' education and training in the use of "heat, cold, air, light, electricity and therapeutic ultrasound."

So if the chiropractors argue that SB 305 will improve access to care and improve the quality of care, we have to stick to our guns and ask the original question, "Do chiropractors have the medical education and the clinical training necessary to do these procedures?"

Continued on page 63



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Contraindications: Severe LV dysfunction (see **Warnings**), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbo KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbo K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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- A historical account of the 1892 MSMS House of Delegates meeting
- AMA House of Delegates Meeting Highlights
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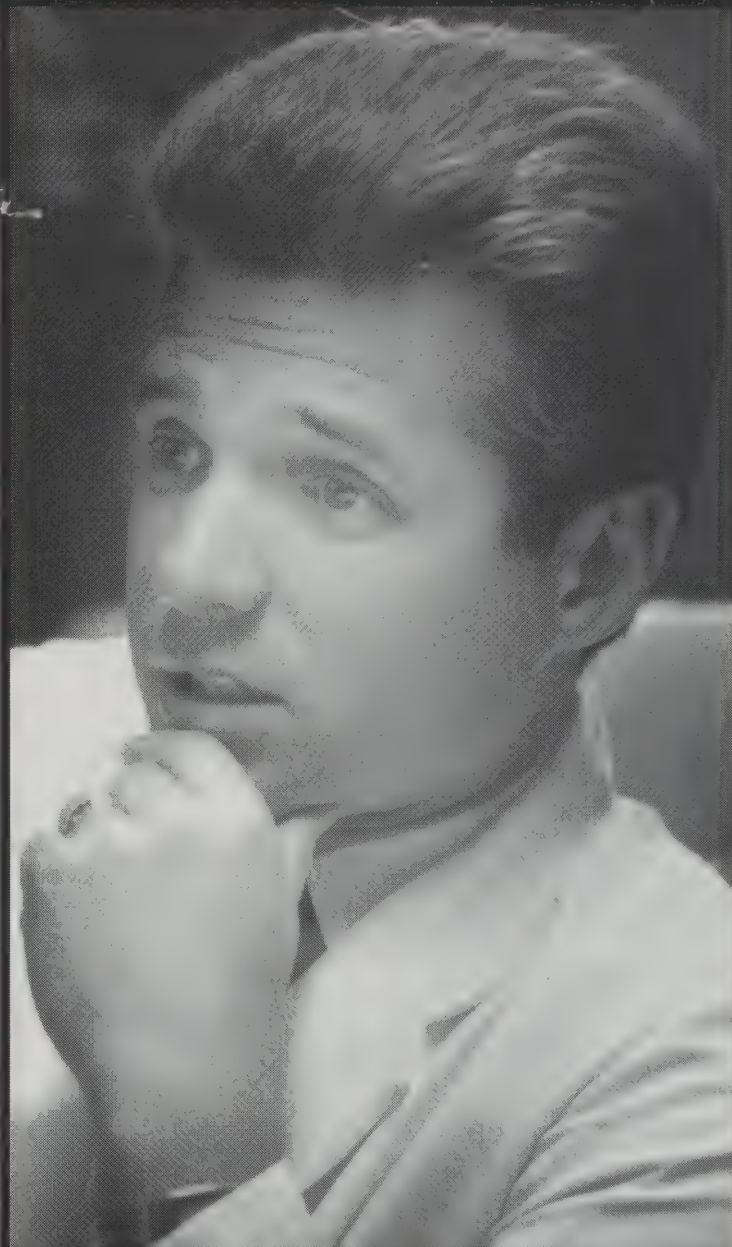
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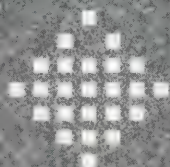
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VOLUME 91, NO. 8

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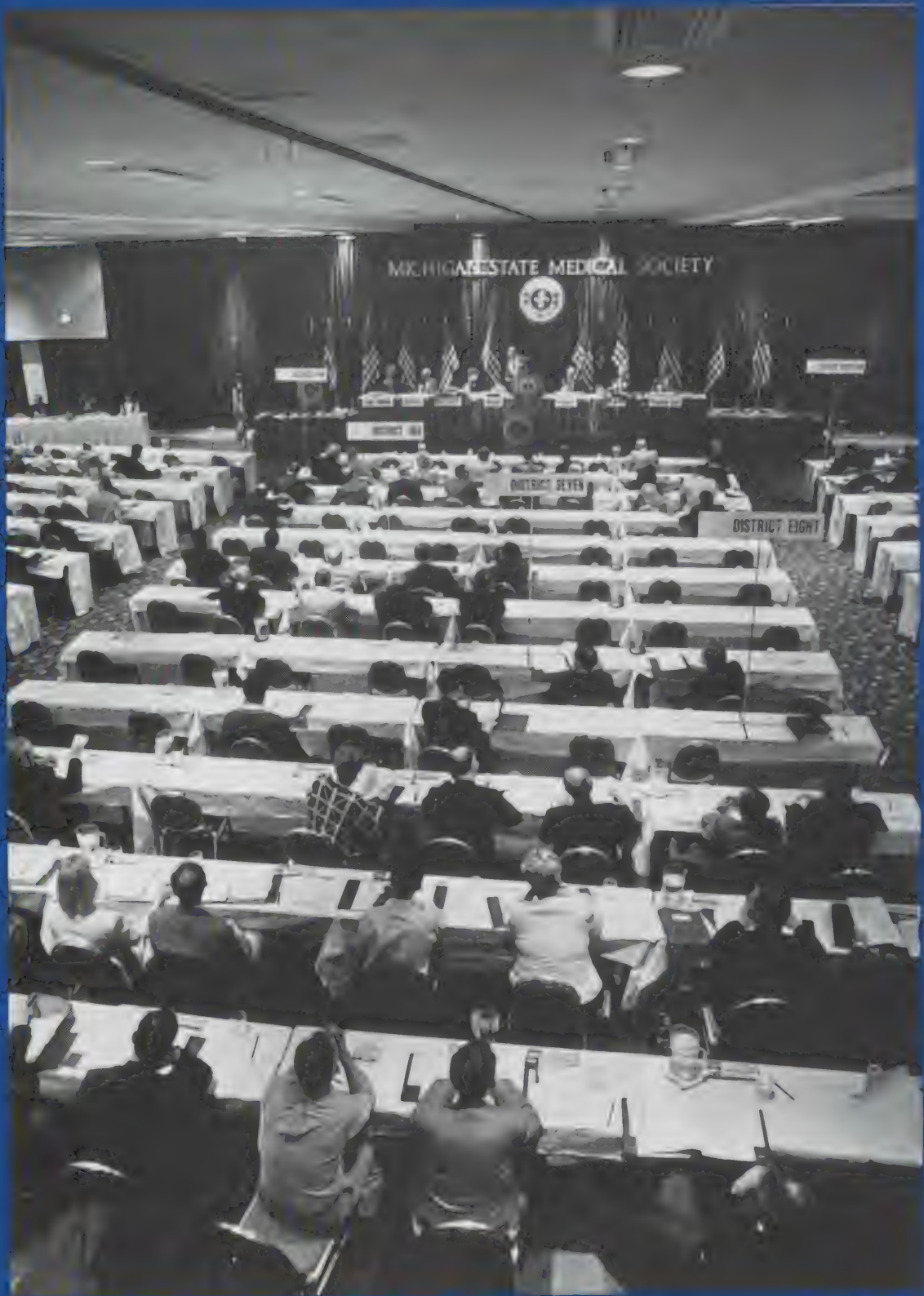
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What do you do when you go back home?

Thomas C. Payne, MD

Editor's note: Following are excerpts of the inaugural address given by MSMS President Thomas C. Payne, MD, at the MSMS House of Delegates Meeting.

I want to take this opportunity to thank the delegate body for the privilege of serving as president. Particular thanks goes to the physicians of Ingham County and the support that they have given me over the years. This is a rare opportunity and with your help I will try to make the most of it. I do not take this honor lightly as I realize I am following some large footsteps. I will do my best to represent the House of Medicine in the upcoming year.

One year ago, your incoming president, and my good friend, Robert Burton, MD, started his inaugural address by making an analogy between marriage and medical issues. His talk centered around something old, something new, something borrowed and something blue. The old was professional liability. A lot has happened in the past year but more needs to be done. Legislation has passed the Senate but now languishes in the House. We remain optimistic that positive action will be taken in the not too distant future.

Something new was turf issues — expansion of scope of practice specifically as it relates to optometry and chiropractic. Optometry legislation has passed the House and is waiting for the Senate action. Chiropractic legislation was introduced into the Senate first and now has become one of the most politicized medical issues we face.

Something borrowed was ethical issues, specifically physician-assisted suicide. Doctor Kevorkian has assisted two more females in the past year in their death wishes. Regardless of how you feel about him and the issue, he has brought it to the forefront of medical issues physicians must deal with.

Something blue! What else but Blue Cross/Blue



Shield. Blue Cross/Blue Shield of Michigan has come under scrutiny, not only by organized medicine but by the court system. That Borsos decision says Blue Cross/Blue Shield has done wrong. Will this make them more accountable or not? Great strides have been made through our Liaison Committee and the Physician Contract Advisory Committee as well as a committee formed to address the provider class plan. Again, much more needs to be done and I am sure will always need to be done as we deal with Blue Cross/Blue Shield.

Five key topics

You have heard about the past, now indulge me and hear some of my thoughts about the future. Instead of four items, I have selected five. These are items to think about and ponder and then to take home to your own counties and decide what might work there.

One: Participation

The first of my five topics is **participation**. Board members and delegates here today are participating in this important meeting, but will you participate when you return home? On a continuing basis? Ask yourself these questions:

- Do you have regular meetings?
- Do you have specific topics?
- Do you accomplish anything?

Here are some ideas:

1. Have you introduced to your local county "Durable Power of Attorney" and made it available to people living in your community?
2. Have you met regularly with your legislators about issues that affect not only you but everyone who lives in your community?
3. Have you worked to accomplish a voluntary assignment program?

I could suggest many more but will only challenge

you to come up with what will work best for your county.

Two: Representation

By representation, I mean how are you representing your profession to those outside of medicine? Are you a member of service clubs, be it Rotary or Kiwanis or whatever?

Are you talking to them about timely issues such as physician-assisted suicide, health care delivery or health care reform? Are you a member of your Chamber of Commerce? Are you a member of your school board? Are you a participating member of your community?

Three: Involvement

You are already participating by being here, but have you become involved in doing something between meetings of the House of Delegates? For example:

- Have you participated in our "Doctor of the Day" program? If you haven't, you are missing out on an unusual experience. Please come down and spend a day with us in Lansing and find out how the legislature works.
- Have you come to Lansing to testify on a specific issue? Let us at the Medical Society know your interests so that you and your expertise can be utilized. Again, this is an experience every physician should have.
- Are you working with your own local media, be it radio, television or newspaper?
- Do you write editorials for your own county bulletin?

Four: Dedication

We in Ingham County have had an actively functioning Legislative Committee. Many other counties have too. Do you participate with yours?

Do you have contact with your legislators? County societies should have a mechanism where they interview candidates who are running for office, be it a state or federal office. Interview them and support those that you feel would be supportive of medicine. Support not only your local candidates through your time and effort and contributions but support your Michigan Doctors Political Action Committee. It is through the PAC Committee that the legislators gauge the position of medicine on the specific issues. Please join!

Five: Environment

Originally, I thought the theme of my presidency would be the "outside" environment. But after much reflection, I chose the "inside" environment, that is, domestic violence. We have all heard a lot about child abuse, less about child sexual abuse and even less about spouse abuse and elder abuse. The direction of my theme follows several courses:

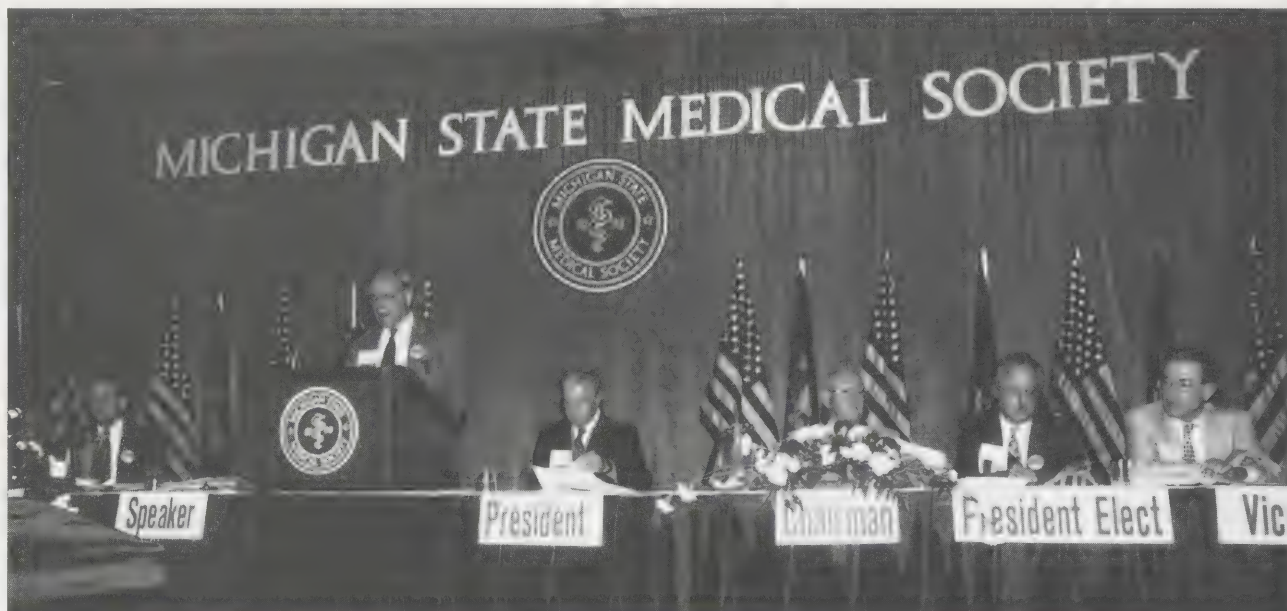
1. *Informational*: We are just seeing the tip of the iceberg. We need to know more about the scope of the problem.
2. *Awareness*: Physicians must be made more aware of the problem and then be able to recognize it. We need to have a much higher index of suspicion. Let us learn to ask the right questions of our patients. Here is a specific example: Doctor Robert McAfee, vice chairman of the AMA Board of Trustees who is leading the AMA's program, asked a patient who exhibited bruises, do you bruise easily? This brought forth a torrent of tears and words showing that she, indeed, was a victim of violence.
3. *Legal Ramifications*: What can you do and what should you do? Reporting requirements vary greatly — especially for child abuse and spouse abuse.
4. *Working with Community Agencies*: Each community has certain agencies that are pursuing the problem, but there needs to be a more coordinated approach and I am sure that we physicians can help.
5. *Procedures and Protocols*: The AMA is presently developing specific procedures and protocols for dealing with these problems.

I've given you some ideas of what you can do when you go back home. I hope that you take these ideas home with you and then use at least one.



Newly-installed MSMS President Thomas C. Payne, MD, (right) shares a light-hearted moment with MSMS Vice Speaker Gary D. Maynard, MD, (left) at the President's Banquet held Saturday evening.

As you can see, the challenges are tough and diverse, I haven't given up and I hope that you haven't either. Take participation, representation, involvement, dedication and environment and what do you have? You have PRIDE. That is what I have in my profession and I hope you do, too. If we all have pride we can work together to make a difference. ■



MSMS Speaker Robert D. Allaben, MD, instructs members of the House from the podium during the MSMS House of Delegates meeting held at the Hyatt Regency Dearborn.

■ CALL TO ORDER & SPECIAL REPORTS ■

Michigan State Medical Society House of Delegates 127th Annual Session May 1-3, 1992

Call to Order

The 127th Annual Session of the House of Delegates of the Michigan State Medical Society convened at 7:30 pm at the Hyatt Regency, Dearborn. Speaker Robert D. Allaben, MD, and Vice-Speaker Gary D. Maynard, MD, presiding.

Invocation

The Speaker called upon Arthur A. Ulmer, MD, to give the invocation.

Report of the Committee on Credentials and Tellers

Chairman Steven S. Bolton, MD, reported a quorum seated, the majority of whom were not from any one county.

Report of the Committee on Rules and Order of Business

Chairman Reed K. Freidinger, MD, reported the actions of the Committee on Rules and Order of Business as follows:

Order of Business: The Committee on Rules and Order of Business approved the Order of Business for the 1992 Annual Session as printed in the Delegates' Handbook.

Late Resolutions: Four late resolutions were presented to the Committee.

Resolution 115-92A "Tort Reform March on Lansing by Doctors," submitted by Edward E. Elder, Jr., MD, for the Oakland County Delegation.

Committee Recommendation: That this resolution not be accepted for introduction.

Resolution 116-92A "MSMS Protest NBC Program on International Medical Schools," submitted by Busharat Ahmad, MD, Marquette-Alger County.

Committee Recommendation: That this resolution be accepted.

Resolution 117-92A "Incorporation of Component County Medical Societies," submitted by Samir M. Ragheb, MD, Macomb County.

Committee Recommendation: That this resolution not be accepted for introduction.

Resolution 118-92A "AMA Amicus Curiae Brief to Exempt Pension Assets from Bankruptcy," submitted by Gary D. Maynard, MD, for the Board of Directors.

Committee Recommendation: That this resolution be accepted.

RESOLUTIONS

1-92A	Timely Medicaid Payments	12	35-92A	Arrange International Meetings with Various Ethnic Organizations	15	78-92A	Encourage Hospitals To Develop Bioethics Committees	20
2-92A	HIV Testing	12	36-92A	Continuation of MSMS Section for International Medical Graduates (IMGs)	15	79-92A	Resolution in Support of Zero Discharge of PCB/Dioxin Compounds in the Great Lakes Basin	20
3-92A	Alternative Forms of National Health Insurance	12	37-92A	National Credential Verification System (NCVS)	15	80-92A	Keep Physicians and Hospital Fees Separate	20
4-92A	Uniform Billing Form	12	38-92A	Amendment to the Michigan Medical Practice Act	15	81-92A	Tobacco-Free Schools	20
5-92A	Medicaid Sterilization Consent Requirement	12	39-92A	Form International Medical Graduate (IMG) Committees at the County Level	15	82-92A	Tobacco Tax Increase	20
6-92A	Credentiaing Verification Services	12	40-92A	Request AMA to Encourage All States to Form International Medical Graduates (IMGs) Sections	15	83-92A	Determination of Medical Necessity by Treating Physicians	20
7-92A	Proposed Reduced Dues for New Members	12	41-92A	Charging for MSMS Staff Labor for CME Programs	15	84-92A	Support of House Bill 5027	20
8-92A	Funding for Two Hospital Medical Staff Section Governing Council Members to Attend AMA Leadership Conference	12	42-92A	Incentives for Arbitration	15	85-92A	Establish a Mechanism for Investigating Perception of Conflicts of Interest	20
9-92A	Audit System for the New Current Procedural Terminology (CPT) Codes in Physicians Offices	12	43-92A	Blue Care Network Advertising	16	86-92A	Peer Review Immunity	20
10-92A	Open Forum for Health Reform and Health Access	13	44-92A	MSMS Members to participate in Community Coalitions	16	87-92A	Statistics Availability	20
11-92A	Consolidated Omnibus Budget Reconciliation Act (COBRA) Anti-Dumping Criteria	13	45-92A	Liability Protection for Volunteerism in Medicine	16	88-92A	Save Our Babies	20
12-92A	State Medical Boards Funding	13	46-92A	Uniform Current Procedural Terminology (CPT) Coding	16	89-92A	Forced Electronic Billing	21
13-92A	Michigan Peer Review Organization (MPRO) Make Available 800 Telephone Number to Michigan Physicians	13	47-92A	Quality Post-Operative Care for the Patient	16	90-92A	AMA Approved Fellowships	21
14-92A	Registration of Utilization Review Firms by States	13	48-92A	Charging Continuing Medical Education (CME) Programs for MSMS Staff Labor	16	91-92A	Overhaul of Michigan's Domestic Violence Laws	21
15-92A	Educate Michigan Physicians Concerning Risks of Off-Shore Medical Liability Insurance Companies	13	49-92A	Pre-Existing Disease Coverage	16	92-92A	Health Care Financing Administration (HCFA) Sanctions of Standard of Care	21
16-92A	Hospital Support for Medical Staff Officers Attending "Medical Leadership Training Programs"	13	50-92A	Insurance Deductibles	16	93-92A	Health Care Financing Administration (HCFA) Care Guidelines Publication to All Physicians	21
17-92A	Off-Site Michigan Peer Review Organization (MPRO) Review of Medical Records	13	51-92A	Standardized Claim Form for Medical Services	16	94-92A	Prohibit Tobacco Sale in Health Related Facilities	21
18-92A	Hospital Efforts to Control, Dictate, Influence, or Regulate Fees Charged by Practicing Physicians	13	52-92A	Taxation of Medical Insurance Premiums	16	95-92A	HIV Testing	21
19-92A	"Pronouncing" in Hospital Deaths	14	53-92A	Ban on Riding in the Back of Pickup Trucks	16	96-92A	Interest-Free Loans	21
20-92A	Simplified Current Procedural Terminology (CPT) Coding	14	54-92A	Childhood Immunizations	16	97-92A	Oppose Assisted Suicide	21
21-92A	Ban on Alcohol Related Advertising	14	55-92A	Family Violence	16	98-92A	Health Care Financing Administration (HCFA) and Office Billing	21
22-92A	Safe Sex and Television	14	56-92A	Hospital Credentials Processing	18	99-92A	Blue Cross Blue Shield of Michigan (BCBSM) Subscriber Payments	21
23-92A	Use of Actual Cost Data for Practice Expense and Professional Liability Relative Value Units	14	57-92A	Language Fluency Tests for International Medical Graduates	18	100-92A	Reduction in the Cost of Medical School Education	21
24-92A	Michigan Department of Public Health (MDPH) Authenticate Complaints and Schedule Complaint Investigations	14	58-92A	Latchkey Children and Guns at Home	18	101-92A	Assisted Suicide	21
25-92A	Pay Expenses for International Medical Graduate's Section Chairman to Attend AMA Leadership Conference	14	59-92A	Limits on Weight Wrestlers Can Lose	18	102-92A	Changes in Billing Procedures	21
26-92A	International Medical Graduates (IMG's) Support of Free Medical Clinics for the Poor	14	60-92A	Mandatory Air Bags in All Motor Vehicles	18	103-92A	Support for Barrier-Free Immunizations for Children	21
27-92A	Request AMA to Encourage State Licensing Boards to utilize National Credential Verification System (NCVS) for Reciprocal Licensing	14	61-92A	Physicians Responsibility for Reporting Cases of Violence	18	104-92A	Support for the Newborn Hepatitis B Immunization Project Conducted by the Michigan Department of Public Health (MDPH)	22
28-92A	Oversight Committee to Study Differences in Reciprocal Licensing	14	62-92A	Primary Care Manpower Needs	18	105-92A	Increased Support for Public Health Programs to Combat HIV Infections and AIDS in Wayne County	22
29-92A	Liability Protection for Physicians Who Provide Indigent Care	14	63-92A	Spaying/Neutering of Pets	18	106-92A	Unified Membership	22
30-92A	Continuation of Accent Reduction & Communication Skills Seminars	14	64-92A	Conversion of Unused Railroad Beds to Bicycle and Hiking Trails	18	107-92A	Medical Waste Disposal Costs	22
31-92A	Encourage International Medical Graduates (IMGs) Involvement at the County Level	14	65-92A	Inappropriate Curtailment Of Mental Health Services	18	108-92A	Health Insurance For Those Who Have None	22
32-92A	Extension of AMA International Medical Graduates (IMGs) to a Six Year Term	15	66-92A	Health Care Financing Administration (HCFA) Proposal To Centralize All Peer Review Screening Data Collection, and Abstraction Activities Into Five Regional Central Data Abstraction Centers	19	109-92A	23 Hour Hospital Admissions	22
33-92A	Appointment of International Medical Graduates (IMGs) to Various Commissions by the AMA	15	67-92A	Primary Care Manpower Needs	19	110-92A	Delays in Medicare Payment	22
34-92A	National Credential Verification Service (NCVS) Fee Alternatives for New International Medical Graduates (IMGs) and New AMA Members	15	68-92A	Plan For Indigent And Uninsured Care In Michigan	19	111-92A	Support for 911 Services	22
			69-92A	Physician Assisted Suicide Not A Felony	19	112-92A	Expert Witness Panel	22
			70-92A	Prescription Writing-Narcotics	19	113-92A	Office Lab and Imaging	22
			71-92A	Bone Mass Measurement	19	114-92A	Commendation Honoring the County Medical Societies and Senior Citizen Organizations for Implementing Medicare Voluntary Assignment Programs	22
			72-92A	Seek Reversal of EKG Interpretation Rules	19	115-92A	Tort Reform March on Lansing by Doctors	22
			73-92A	Explain to the Public the Costs of Health Care Other Than Physicians Reimbursement.	19	116-92A	MSMS Protest NBC Program on International Medical Schools	22
			74-92A	Requirements For No Smoking in Food Serving Establishments in Michigan	19	117-92A	Incorporation of Component County Medical Societies	22
			75-92A	Elimination of Residents' Membership Dues	19	118-92A	AMA Amicus Curiae Brief to Exempt Pension Assets From Bankruptcy	22
			76-92A	Pursue Legislative Relief from Malpractice Risk for Physicians Who Provide Free Care	19			
			77-92A	Reinstitution of an Adequate Safety Net for Michigan's Former General Assistance Population	19			

■ HOUSE ACTION ON RESOLUTIONS ■

1-92A

Timely Medicaid Payments.

V. Dale Barker, MD, Oceana for Steven R. Lessens, MD

ADOPTED AS AMENDED.

RESOLVED: That MSMS ask the Michigan Department of Social Services to follow the same rules concerning timely Medicaid reimbursement to physicians and hospitals as all other government agencies such as Medicare; and be it further

RESOLVED: That interest should accrue if those payments are not made in a timely manner according to current rules of credit used by the Federal Government under Medicare reimbursement.

2-92A

HIV Testing.

Louis E. Sanford, MD, Ionia-Montcalm

ADOPTED.

RESOLVED: That MSMS request the Michigan Legislature to abolish the written informed consent for HIV testing.

3-92A

Alternative Forms of National Health Insurance.

Louis E. Sanford, MD, Ionia-Montcalm

NO ACTION.

4-92A

Uniform Billing Form.

Louis E. Sanford, MD, Ionia-Montcalm

NO ACTION.

5-92A

Medicaid Sterilization Consent Requirement.

Thomas M. George, MD, Kalamazoo

ADOPTED.

RESOLVED: That MSMS work to revise State Medicaid policy which requires physicians to submit a copy of an "Informed Consent to Sterilization Form" when filing a Medicaid claims form for anesthesia or surgical services for hysterectomies and other sterilization procedures; and be it further

RESOLVED: That the MSMS Delegation to the AMA submit a resolution to the AMA House of Delegates asking the AMA to work to revise federal Medicaid policy which requires physicians to complete an "Informed Consent to Sterilization Form" prior to performing a hysterectomy or other sterilization procedures.

6-92A

Credentialling Verification Services.

John A. Rupke, MD, for the Hospital Medical Staff Section

SUBSTITUTE RESOLUTION (IN LIEU OF 6-92A, 37-92A AND 56-92A AND BOARD RPT. 21). ADOPTED

RESOLVED: That MSMS endorse and support the National Credential Verification Service (NCVS) of the AMA; and be it further

RESOLVED: That the MSMS House of Delegates adopt the recommendations in Board Action Report #21, to actively promote the development of a central credentialling office for Michigan physicians in conjunction with the Michigan Hospital Association and other affected groups utilizing the NCVS information; and be it further

RESOLVED: That MSMS encourage Michigan physicians to deposit credentialling information into the NCVS database; and be it further

RESOLVED: That MSMS encourage the Michigan Board of Medicine, hospitals and other health care organizations to recognize and use the centralized services as developed by MSMS and the AMA.

7-92A

Proposed Reduced Dues for New Members.

John A. Rupke, MD for the Hospital Medical Staff Section

ADOPTED.

RESOLVED: That MSMS review its dues system and attempt to institute a reduced dues rate for physicians who have been in practice for less than five years and are joining MSMS for the first time; and be it further

RESOLVED: That the Michigan Delegation to the AMA request the AMA to review its dues system and attempt to institute a reduced dues rate for physicians who have been in practice for less than five years, and are joining the AMA for the first time.

8-92A

Funding for Two Hospital Medical Staff Section Governing Council Members to Attend AMA Leadership Conference.

John A. Rupke, MD, for the Hospital Medical Staff Section

DISAPPROVED.

9-92A

Audit System for the New Current Procedural Terminology (CPT)



The MSMS House of Delegates considered 116 resolutions, 18 action reports and 14 informational reports during its meeting in May. Two of the more hotly-debated topics were informed consent for HIV testing and physician-assisted suicide.

Codes in Physician's Offices.

John A. Rupke, MD for the Hospital Medical Staff Section

ADOPTED.

RESOLVED: That MSMS develop an audit system for the new CPT codes so physicians can determine whether their charges and utilization codes are correct and appropriate; and be it further

RESOLVED: That the Michigan Delegation to the AMA request the AMA to develop an audit system for the new CPT codes so physicians can determine whether their charges and utilization codes are correct and appropriate.

10-92A

Open Forum for Health Reform and Health Access.

John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS ask the AMA to schedule open forums around the nation for people interested in health reforms and develop communication between legislative bodies, the public, and the medical profession; and be it further

RESOLVED: That MSMS emphasize to county societies the need for county officers or others to participate in local health forums.

11-92A

Consolidated Omnibus Budget Reconciliation Act (COBRA) Anti-Dumping Criteria.

John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED.

RESOLVED: That MSMS educate physicians and encourage the Michigan Hospital Association to educate hospital administrators to the implications and responsibilities of the COBRA anti-dumping regulations.

12-92A

State Medical Boards Funding.

John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS request accounting on a continual basis from the State of Michigan regarding the allocation of medical licensure fees; and be it further

RESOLVED: That this information be reported to MSMS members.



A resolution addressing informed consent for HIV testing brought several physicians to their feet at the MSMS House of Delegates meeting. The resolution called for MSMS to request the Michigan Legislature to abolish the written informed consent for HIV testing. Ultimately, the resolution was adopted without changes.

13-92A

Michigan Peer Review Organization (MPRO) Make Available 800 Telephone Number to Michigan Physicians.

John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED.

RESOLVED: That MSMS continue to request MPRO to maintain an 800 number, advise Michigan physicians of its existence in all communications, and adequately staff such service.

14-92A

Registration of Utilization Review Firms by States.

John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS affirm that utilization review firms employed by insurance companies be held accountable for medical decisions that are based on their review; and be it further

RESOLVED: That MSMS seek legislation to require utilization review firms to register with the state and provide information to physicians and hospitals, including but not limited to:

1. Methods used to establish, modify, and update their standards and procedures, including their criteria for denial.
2. An outline of the procedures that patients, physicians, or hospitals must follow in order to appeal decisions that are made by the reviewer.
3. Documentation regarding their employee qualifications to perform utilization review.
4. A copy of their policy pertaining to the confidentiality of medical records.

15-92A

Educate Michigan Physicians Concerning Risks of Off-Shore Medical Liability Insurance Companies.

John A. Rupke, MD, for the Hospital Medical Staff Section

SUBSTITUTE RESOLUTION 15-92A. ADOPTED.

RESOLVED: That MSMS educate Michigan physicians concerning the benefits and risks of purchasing medical liability insurance from off-shore insurance companies.

16-92A

Hospital Support for Medical Staff Officers Attending "Medical Leadership Training Programs."

John A. Rupke, MD, for the Hospital Medical Staff Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS encourage medical staffs to support attendance at appropriate national "medical leadership training meetings" by their president-elect or other elected or appointed officers.

17-92A

Off-Site Michigan Peer Review Organization (MPRO) Review of Medical Records.

John A. Rupke, MD for the Hospital Medical Staff Section

NO ACTION.

18-92A

Hospital Efforts to Control, Dictate, Influence, or Regulate Fees Charged by Practicing Physicians.

Continued on following page

John A. Rupke, MD for the Hospital Medical Staff Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS support and intervene where necessary on behalf of physicians who strive to preserve the rights to establish their own fees without hospital interference, regulation, or threat (loss of contract or privileges); and be it further

RESOLVED: That MSMS communicate this resolution to the Michigan Hospital Association and all hospital medical staffs for their use in negotiating with local hospitals.

19-92A

"Pronouncing" in Hospital Deaths.

John A. Rupke, MD, for the Hospital Medical Staff Section
DISAPPROVED.

20-92A

Simplified Current Procedural Terminology (CPT) Coding.

John A. Rupke, MD, for the Hospital Medical Staff Section
DISAPPROVED.

21-92A

Ban on Alcohol Related Advertising.

John A. Rupke, MD, for the Hospital Medical Staff Section
ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to continue to work with interested parties in the ban of advertising of alcohol and alcohol related products in audio/visual media and also consider responsible advertising in written media.

22-92A

Safe Sex and Television.

John A. Rupke, MD, for the Hospital Medical Staff Section
ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to develop a program in concert with other interested parties to reduce the number of sex-related scenes on television during family viewing hours; and be it further

RESOLVED: That MSMS and its component societies communicate with local television stations regarding physicians' concerns that the stations reduce the number of sex-related

scenes on television during family viewing hours.

23-92A

Use of Actual Cost Data for Practice Expense and Professional Liability Relative Value Units.

John A. Rupke, MD, for the Hospital Medical Staff Section
NO ACTION.

24-92A

Michigan Department of Public Health (MDPH) Authenticate Complaints and Schedule Complaint Investigations.

John A. Rupke, MD, for the Hospital Medical Staff Section
ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA advise the AMA of Health Care Financing Administration's (HCFA's) lack of verifying complaints about patient dumping that it receives from patients or institutions and Medicare's lack of notification of visit to investigate those complaints; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to request HCFA to change its contracting standards for patient dumping complaint investigation to require corroborating information prior to investigational surveys, advance scheduling or surveys and an appeal of findings.

25-92A

Pay Expenses for International Medical Graduate's Section Chairman to Attend AMA Leadership Conference.

Allen C. D. Brown, MD, for the Section for International Medical Graduates
DISAPPROVED.

26-92A

International Medical Graduates (IMG's) Support of Free Medical Clinics for the Poor.

Allen C. D. Brown, MD, for the Section for International Medical Graduates
ADOPTED AS AMENDED.

RESOLVED: That MSMS ask each component medical society to report on an annual basis the activity of its members in establishing clinics and other contributions for indigent care; and be it further

RESOLVED: That MSMS communicate these activities to legislators and the news media.

27-92A

Request AMA to Encourage State Licensing Boards to Utilize National Credential Verification System (NCVS) for Reciprocal Licensing.

Allen C.D. Brown, MD, for the Section for International Medical Graduates
NO ACTION.

28-92A

Oversight Committee to Study Differences in Reciprocal Licensing.

Allen C. D. Brown, MD, for the Section for International Medical Graduates
ADOPTED AS AMENDED.

RESOLVED: That MSMS work with the Michigan Department of Commerce to study the differential in time between IMGs and Liaison Committee on Medical Education (LCME) graduates seeking licensure by endorsement in Michigan.

29-92A

Liability Protection for Physicians Who Provide Indigent Care.

Allen C. D. Brown, MD, for the Section for International Medical Graduates
SUBSTITUTE RESOLUTION (IN LIEU OF 29-92A, 45-92A AND 76-92A).

ADOPTED.

RESOLVED: That MSMS support legislation that would provide liability protection for physicians who provide indigent care.

30-92A

Continuation of Accent Reduction and Communication Skills Seminars.

Allen C. D. Brown, MD, for the Section for International Medical Graduates
ADOPTED AS AMENDED.

RESOLVED: That MSMS continue to hold accent reduction and communication skills seminars and other activities for IMGs and other physicians.

31-92A

Encourage International Medical Graduates (IMGs) Involvement at the County Level.

Allen C. D. Brown, MD, for the Section for International Medical Graduates

SUBSTITUTE RESOLUTION (IN LIEU OF 31-92A AND 39-92A). ADOPTED.

RESOLVED: That MSMS encourage county medical societies to involve IMGs in county medical society and hospital peer review processes; and be it further

RESOLVED: That other county medical societies examine the Wayne County election process that includes self-nomination; and be it further

RESOLVED: That MSMS encourage component medical societies to explore the need for the formation of International Medical Graduate committees.

32-92A

Extension of AMA International Medical Graduates (IMGs) to a Six-Year Term.

Allen C. D. Brown, MD, for the Section for International Medical Graduates

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA request the AMA Board of Trustees to extend the life of the AMA IMG Advisory Committee for a six-year period beginning in 1993 and re-review further extensions at that time.

33-92A

Appointment of International Medical Graduates (IMGs) to Various Commissions by the AMA.

Allen C. D. Brown, MD, for the Section for International Medical Graduates

NO ACTION.

34-92A

National Credential Verification Service (NCVS) Fee Alternatives for New International Medical Graduates (IMGs) and New AMA Members.

Allen C. D. Brown, MD, for the Section for International Medical Graduates

NO ACTION.

35-92A

Arrange International Meetings with Various Ethnic Organizations.

Allen C. D. Brown, MD, for the



Six reference committees heard testimony regarding 118 resolutions brought before the MSMS House. Shown here are members of Reference Committee D who heard testimony on resolutions concerning professional liability.

Section for International Medical Graduates

ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to study the feasibility of offering assistance to organized ethnic medical associations within the U.S. in developing overseas medical education programs.

36-92A

Continuation of MSMS Section for International Medical Graduates (IMGs).

Allen C. D. Brown, MD, for the Section for International Medical Graduates

NO ACTION.

37-92A

National Credential Verification System (NCVS).

Allen C. D. Brown, MD, for the Section for International Medical Graduates

SUBSTITUTE RESOLUTION (IN LIEU OF 6-92A, 37-92A, 56-92A AND BOARD REPORT #21). ADOPTED. SEE RESOLUTION 6-92A.

38-92A

Amendment to the Michigan Medical Practice Act.

Allen C. D. Brown, MD, for the Section for International Medical Graduates

ADOPTED AS AMENDED.

RESOLVED: That MSMS seek changes in the current Michigan Medical Practice Act so the act would clearly state opposition to discrimination, including that based on geographical

location of medical education, against any physician licensed in Michigan.

39-92A

Form International Medical Graduate (IMG) Committees at the County Level.

Allen C. D. Brown, MD, for the Section for International Medical Graduates

SUBSTITUTE RESOLUTION (IN LIEU OF 31-92A AND 39-92A). ADOPTED. SEE RESOLUTION 31-92A.

40-92A

Request AMA to Encourage All States to Form International Medical Graduates (IMGs) Sections.

Allen C. D. Brown, MD, for the Section for International Medical Graduates

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA request the AMA to encourage all states to form a Section for International Medical Graduates.

41-92A

Charging for MSMS Staff Labor for CME Programs.

James G. Kornmesser, MD, for the Michigan Section - American College of Obstetrics and Gynecology

DISAPPROVED

42-92A

Incentives for Arbitration.

James G. Kornmesser, MD, for the Michigan Section - American

Continued on following page

College of Obstetrics and Gynecology

ADOPTED AS AMENDED.

RESOLVED: That MSMS pursue statutory reforms and voluntary efforts that would permit the selection of binding arbitration at the time of purchase of health insurance and would permit the carrier of health insurance to offer a cost incentive to make this selection attractive to the purchaser.

43-92A

Blue Care Network Advertising.

M. Gary Robertson, MD, Ottawa, for Theodore S. Vanderveen, MD
DISAPPROVED.

44-92A

MSMS Members to Participate in Community Coalitions.

Edward E. Elder, Jr., MD, for the Oakland County Delegation
ADOPTED.

RESOLVED: That MSMS recognize the activities of community partnerships similar to the Troy Community Coalition in solving health care problems; and be it further

RESOLVED: That MSMS encourage its members to participate in such partnerships.

45-92A

Liability Protection for Volunteerism in Medicine.

Moufid Mitri, MD, for the Oakland County Delegation

SUBSTITUTE RESOLUTION (IN LIEU OF 29-92A, 45-92A AND 76-92A).
ADOPTED AS AMENDED. SEE RESOLUTION 29-92A.

46-92A

Uniform Current Procedural Terminology (CPT) Coding.

Robert S. Levine, MD, for the Oakland County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS support uniform CPT coding for all medical service provided within the State of Michigan; and be it further

RESOLVED: That MSMS inform the appropriate state agencies of the havoc which the non-parallel CPT codes will cause; and be it further

RESOLVED: That MSMS ask appropriate state agencies, commissioners, or the state legislature

to require that there be uniform CPT coding for all medical service provided within the State of Michigan; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to support uniform CPT coding for all third party carriers whether governmental or private.

47-92A

Quality Post-Operative Care for the Patient.

Alan M. Mindin, MD, for the Oakland County Delegation

WITHDRAWN.

48-92A

Charging Continuing Medical Education (CME) Programs for MSMS Staff Labor.

Edward E. Elder, Jr., MD, for the Oakland County Delegation

DISAPPROVED.

49-92A

Pre-Existing Disease Coverage.

Robert S. Levine, MD, for the Oakland County Delegation

ADOPTED.

RESOLVED: That MSMS ask the Michigan Department of Labor, the Insurance Commissioner, and/or the State Legislature to require employers to provide continued health insurance coverage for pre-existing conditions for current (not newly-hired) employees to prevent the loss of coverage for a pre-existing condition for an individual whose insurance was changed for the convenience of the employer.

50-92A

Insurance Deductibles.

Robert S. Levine, MD, for the Oakland County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS ask the Michigan Insurance Commissioner to require that individuals who begin health insurance coverage under a policy which has a deductible clause based on a calendar year to have a deductible proportional to the amount of time for which the individual is covered during the calendar year in which the policy became effective.

51-92A

Standardized Claim Form for Medical Services.

Edward E. Elder, Jr., MD, for the

Oakland County Delegation

NO ACTION.

52-92A

Taxation of Medical Insurance Premiums.

Edward E. Elder, Jr., MD, for the Oakland County Delegation

REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to improve the "Health Access America" campaign by working for changes in federal and state laws to allow small businesses to deduct the cost of health insurance premiums for their employees as a tax credit, rather than simply as a business expense.

53-92A

Ban on Riding in the Back of Pickup Trucks.

Patrick J. Droste, MD, for the Young Physicians Section

ADOPTED.

RESOLVED: That MSMS strongly support state legislation that would prohibit any person from riding in the back of a pickup truck without the use of appropriate restraining devices and protection.

54-92A

Childhood Immunizations.

Patrick J. Droste, MD, for the Young Physicians Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS work with the Michigan Department of Public Health and the Michigan Department of Education to improve compliance with the existing law on childhood immunizations; and be it further

RESOLVED: That copies of immunization records be kept by the child's physician, parents and schools.

55-92A

Family Violence.

Patrick J. Droste, MD, for the Young Physicians Section

SUBSTITUTE RESOLUTION.
ADOPTED.

RESOLVED: That MSMS develop a program for addressing the problem of domestic violence and abuse, utilizing resources such as the work being done by the Hennepin County Medical Society in Minnesota, information and guidelines being

Continued on page 18

JUST PUBLISHED!

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Continued from page 16

developed by the AMA, as well as local Michigan community initiatives.

56-92A

Hospital Credentials Processing. **Patrick J. Droste, MD, for the** **Young Physicians Section**

SUBSTITUTE RESOLUTION (IN LIEU OF 6-92A, 37-92A, 56-92A AND BOARD REPORT #21). ADOPTED. SEE RESOLUTION 6-92A.

57-92A

Language Fluency Tests for **International Medical Graduates.** **Patrick J. Droste, MD, for the** **Young Physicians Section**

ADOPTED.

RESOLVED: That MSMS strongly oppose any legislation requiring individuals to pass a spoken English proficiency test to receive a medical license in the State of Michigan.

58-92A

Latchkey Children and Guns at **Home.**

Patrick J. Droste, MD, for the **Young Physicians Section**

ADOPTED.

RESOLVED: That MSMS support legislation requiring the distribution of educational materials to firearms purchasers such as the use of lock boxes, trigger locks, child proof safety catches, and loading indicators.

59-92A

Limits on Weight Wrestlers Can **Lose.**

Patrick J. Droste, MD, for the

Young Physicians Section

ADOPTED AS AMENDED.

RESOLVED: That MSMS, in recognizing the dangers of excessive rapid weight loss, support formulation of a policy by the Michigan High School Athletic Association (MHSAA) similar to that of the Wisconsin Interscholastic Athletic Association, to put a limit on the weight wrestlers can lose, and to support education of coaches; and be it further

RESOLVED: That MSMS encourage the MHSAA to allocate the number of competition spots in wrestling weight classes in proportion to the normal distribution of weight for established age groups.

60-92A

Mandatory Air Bags in All Motor **Vehicles.**

Patrick J. Droste, MD, for the **Young Physicians Section**

NO ACTION.

61-92A

Physician Responsibility for **Reporting Cases of Violence.**

Patrick J. Droste, MD, for the **Young Physicians Section**

ADOPTED AS AMENDED.

RESOLVED: That MSMS develop guidelines for physicians which detail the reporting requirements of Section 750.411 of the Michigan Penal Code and distribute such guidelines for the education of all Michigan physicians; and be it further

RESOLVED: That MSMS investigate the need to update physicians on all reporting requirements of state and federal laws.

62-92A

Primary Care Manpower Needs. **Patrick J. Droste, MD, for the** **Young Physicians Section**

ADOPTED AS AMENDED.

RESOLVED: That MSMS encourage medical schools to examine their curricula to foster greater exposure to primary care medicine, and to encourage career choices in primary care medicine.

63-92A

Spaying/Neutering of Pets. **Patrick J. Droste, MD, for the** **Young Physicians Section**

ADOPTED.

RESOLVED: That MSMS work with humane societies and veterinary groups to educate the public as to the consequences of great numbers of unwanted animals and the importance of controlling the reproduction of pets.

64-92A

Conversion of Unused Railroad **Beds to Bicycle and Hiking Trails.**

Edgar P. Balcueva, MD, Saginaw, **for Thomas A. Egelston, MD**

ADOPTED.

RESOLVED: That MSMS encourage and support the provision of traffic lanes and trails open to the public use by hikers, joggers and bicyclists; and be it further

RESOLVED: That MSMS join with other interested parties in encouraging State and local governmental agencies to convert unused railroad beds for such use.

65-92A

Inappropriate Curtailment of **Mental Health Services.**

Rhoda M. Powsner, MD, for the **Washtenaw County Medical** **Society**

REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS seek a moratorium on the closing of Coldwater Regional Psychiatric Hospital, the Lafayette Clinic, and similar centers of excellence; and be it further

RESOLVED: That MSMS seek the appointment of the highest levels of administration and clinical programs in the Michigan Department of Mental Health; and be it further

RESOLVED: The MSMS seek mandated close collaboration between community mental health



Delegates considered several difficult, often complex, resolutions brought before the MSMS House in May, as these two Washtenaw County physicians will attest. They are: Marguerite Shearer, MD, (left), a member of the MSMS Board of Directors and an AMA alternate delegate, and Rhoda M. Powsner, MD, (right) an MSMS delegate and AMA alternate delegate.

centers and the private and public hospitals; and be it further

RESOLVED: That MSMS request Governor Engler to appoint an Ad Hoc Task Force to design a plan for integrating inpatient and outpatient services in a cost-effective manner by September 1992, and that this Task Force be composed of psychiatrists and other representatives of hospital and community mental health services in both the public and private domains.

66-92A

Health Care Financing Administration (HCFA) Proposal to Centralize All Peer Review Screening, Data Collection, and Abstraction Activities into Five Regional Central Data Abstracting Centers.

L. Paul Sonda, MD, for the Washtenaw County Medical Society

REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS oppose the establishment of Central Data Abstracting Centers (CDACs); and be it further

RESOLVED: That MSMS urge HCFA to maintain and preserve the performance of all peer review activities within each state to designated statewide peer review organizations as currently done and as required by law.

67-92A

Primary Care Manpower Needs.

Karl J. Edelmann, MD, for the Washtenaw County Medical Society

ADOPTED AS AMENDED.

RESOLVED: That MSMS in coordination with primary care specialty societies in Michigan, develop appropriate incentives to increase the number of graduates choosing primary care specialties; and be it further

RESOLVED: That the MSMS Board of Directors investigate the appropriateness of developing legislation, long-term strategies or other means to ensure adequate patient access to primary care.

68-92A

Plan for Indigent and Uninsured Care in Michigan.

Karl J. Edelmann, MD, for the Washtenaw County Medical Society

DISAPPROVED.

69-92A

Physician-Assisted Suicide Not A Felony.

James B. Kilway, MD, Kalamazoo

ADOPTED AS AMENDED.

RESOLVED: That the MSMS Board of Directors rescind its action of January 15, 1992, to support legislation to make physician-assisted suicide a felony; and be it further

RESOLVED: That MSMS continue to sponsor forums and discussions under the aegis of the Bioethics Committee on the issue of physician's role at the time of death; and be it further

RESOLVED: That MSMS recommend that *no legislation* be sought related to physician-related suicide at this time.

70-92A

Prescription Writing-Narcotics.

Kenneth A. Weinberger, MD, Macomb

ADOPTED.

RESOLVED: That MSMS request a study by the State of Michigan to see if the change in prescription writing for narcotics has resulted in less diversion of prescription narcotics from the intended patient.

71-92A

Bone Mass Measurement.

Kenneth A. Weinberger, MD, Macomb

DISAPPROVED.

72-92A

Seek Reversal of EKG Interpretation Rules.

Cyrus Farrehi, MD, for the Genesee County Medical Society

ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA recommend that the AMA use its offices and cooperate with societies to prevent rules such as elimination of Medicare payments for interpretation of EKGs before they arise, or reverse such rules as they occur.

73-92A

Explain to the Public the Costs of Health Care Other Than Physicians Reimbursement.

Cyrus Farrehi, MD, for the Genesee County Medical Society

ADOPTED AS AMENDED.

RESOLVED: That MSMS emphasize

to the public the fact that there are many components of health care costs besides those related to physicians; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to increase efforts to publicize the fact that there are many components of health care costs besides those related to physicians, including but not limited to price of drugs, equipment and supplies, ambulance transportation, non-physician personnel, hospital and other institutional charges, AIDS, alcohol abuse, tobacco use, violence and health care administration cost.

74-92A

Requirements for No Smoking in Food Serving Establishments in Michigan.

Cyrus Farrehi, MD, for the Genesee County Medical Society

ADOPTED AS AMENDED.

RESOLVED: That MSMS seek legislative action requiring that smoking not be allowed in restaurants in the State of Michigan; and be it further

RESOLVED: That MSMS encourage county medical societies to become active in promoting adoption of local ordinances to ban smoking in restaurants.

75-92A

Elimination of Residents' Membership Dues.

Siavosh Varjavandi, MD, for the Genesee County Medical Society
NO ACTION.

76-92A

Pursue Legislative Relief from Malpractice Risk for Physicians Who Provide Free Care.

Vivian M. Lewis, MD, for the Genesee County Medical Society

SUBSTITUTE RESOLUTION (IN LIEU OF 29-92A, 45-92A AND 76-92A).
ADOPTED AS AMENDED. SEE RESOLUTION 29-92A.

77-92A

Reinstitution of an Adequate Safety Net for Michigan's Former General Assistance Population.

Allen F. Turcke, MD, for the Genesee County Medical Society

ADOPTED AS AMENDED.

RESOLVED: That MSMS formally

Continued on following page

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request the State Legislature and the Governor to reinstate health care for the former General Assistance population.

78-92A

Encourage Hospitals to Develop Bioethics Committees.

W. Archibald Piper, MD, for the Genesee County Medical Society

ADOPTED AS AMENDED.

RESOLVED: That MSMS encourage medical staffs to work with their hospitals to implement bioethics committees; and be it further

RESOLVED: That MSMS, in conjunction with the Michigan Hospital Association, inform all hospitals and medical staffs about the existence of the Medical Ethics Resource Network.

81-92A

Tobacco-Free Schools.

William Doebler, MD, Ottawa

ADOPTED AS AMENDED.

RESOLVED: That MSMS encourage all Michigan schools up through 12th grade to adopt a tobacco-free school policy that prohibits the use of tobacco products in school buildings and vehicles and on school grounds by anyone at any time.

82-92A

Tobacco Tax Increase.

William Doebler, MD, Ottawa

ADOPTED.

RESOLVED: That MSMS urge Governor Engler and the Michigan Legislature to support a tobacco tax increase as a health initiative for Michigan's future.

Investigating Perceptions of Conflicts of Interest.

Robert Holmes, MD, Martin Jones, MD, and David K. Johnson, MD, Ingham, for Floyd G. Goodman, MD

SUBSTITUTE RESOLUTION. ADOPTED.

RESOLVED: That MSMS establish a mechanism for investigating any possible perception of conflicts of interest arising between MSMS leadership and insurance carriers, third party payers or any other entities.

86-92A

Peer Review Immunity.

Robert C. Packer, MD, Muskegon

ADOPTED.

RESOLVED: That MSMS investigate the current "state doctrine" of Michigan to determine if it is structured to provide federal antitrust immunity to physicians involved in contested hospital privileging activities; and be it further

RESOLVED: That if the current "state doctrine" is found not to provide the immunity, MSMS will determine if it would be desirable for the State of Michigan to change its peer review laws to provide this immunity; and be it further

RESOLVED: That if it is found that such a change is desirable and would give added protection to physicians involved in these activities, MSMS will undertake to effect the necessary changes in the "state action" doctrine to satisfy the requirement of "active supervision."

87-92A

Statistics Availability.

Steven E. Olchowski, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS establish a method and means to gather and supply statistics, data and information to county societies and physicians as requested.

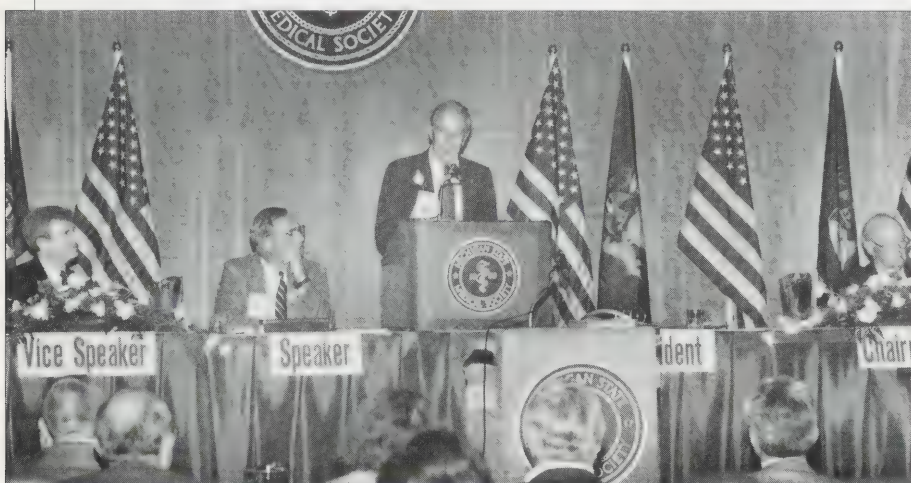
88-92A

Save Our Babies.

Samuel Indenbaum, MD, for the Wayne County Delegation

ADOPTED.

RESOLVED: That MSMS seek legislation to develop a warning notice clearly stating the harm of alcohol use during pregnancy and to require this notice to be exhibited in a prominent



MSMS President Robert D. Burton, MD, (at podium) addresses delegates, alternate delegates and guests attending the MSMS House of Delegates meeting in Dearborn.

79-92A

Resolution in Support of Zero Discharge of PCB/Dioxin Compounds in the Great Lakes Basin.

Ali Esfahani, MD, for the Genesee County Medical Society

ADOPTED.

RESOLVED: That MSMS support the goal of "zero discharge" for PCB/dioxin compounds in the Great Lakes Basin.

80-92A

Keep Physician and Hospital Fees Separate.

Cyrus Farrehi, MD, for the Genesee County Medical Society

NO ACTION.

83-92A

Determination of Medical Necessity by Treating Physicians.

Robert Holmes, MD, Martin Jones, MD, and David K. Johnson, MD, Ingham, for Floyd G. Goodman, MD

NO ACTION.

84-92A

Support of House Bill 5027.

Robert Holmes, MD, Martin Jones, MD, and David K. Johnson, MD, Ingham, for Floyd G. Goodman, MD

NO ACTION.

85-92A

Establish a Mechanism for

location at every bar or restaurant that serve alcohol.

89-92A

Forced Electronic Billing.

Magdy Hanna, MD, for the Wayne County Delegation

NO ACTION.

90-92A

AMA Approved Fellowships.

Steven E. Olchowski, MD, for the Wayne County Delegation

REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That the Michigan Delegation to the AMA request the AMA to seek changes so that osteopathic residents from AOA approved programs be allowed to qualify for all Liaison Committee on Medical Education fellowship programs.

91-92A

Overhaul of Michigan's Domestic Violence Laws.

Firooz Banooni, MD, for the Wayne County Delegation

ADOPTED.

RESOLVED: That MSMS support and seek passage of the current domestic violence bills before the Legislature that would require police to make arrests when there is probable cause to believe abuse has occurred, allow a person to obtain an injunction prohibiting threats of death or serious harm and require a prosecutor to prosecute those who violate an injunction, increasing penalties for repeated domestic assaults and require the abuser to enter a counseling program.

92-92A

Health Care Financing Administration (HCFA) Sanctions on Standard of Care.

Firooz Banooni, MD, for the Wayne County Delegation

NO ACTION.

93-92A

Health Care Financing Administration (HCFA) Care Guidelines Publication to All Physicians.

Firooz Banooni, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS work through the Michigan Congressional

Delegation and the AMA to insist that HCFA make available the guidelines used for review to all physicians by June 1, 1993.

94-92A

Prohibit Tobacco Sale in Health-Related Facilities.

Samuel Indenbaum, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS seek legislation which would prohibit the sale, use, and advertising of tobacco products in any health-related facility or business receiving public funds.

95-92A

HIV Testing.

Samuel Indenbaum, MD, for the Wayne County Delegation

ADOPTED.

RESOLVED: That MSMS seek legislation to allow physicians to perform HIV testing on patients as they feel it is indicated to appropriately perform medical management of their patient without fear of liability.

96-92A

Interest-Free Loans.

Samuel Indenbaum, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS seek legislation to require BCBSM and medical insurers to make available to physicians advance payment when slow-downs in claims processing delay normal payments; and be it further
RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek legislation requiring Medicare to make available to physicians advance payment when slow-downs in claims processing delay normal payments.

97-92A

Oppose Assisted Suicide.

Samuel Indenbaum, MD, for the Wayne County Delegation

DISAPPROVED.

98-92A

Health Care Financing Administration (HCFA) and Office Billing.

Jack Shapiro, MD, for the Wayne County Delegation

DISAPPROVED.

99-92A

Blue Cross Blue Shield of

Michigan (BCBSM) Subscriber Payments.

Cecil R. Jonas, MD, for the Wayne County Delegation

DISAPPROVED.

100-92A

Reduction in the Cost of Medical School Education.

Steven E. Olchowski, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to work with all appropriate bodies to study how the cost of medical education can be reduced significantly in coming years.

101-92A

Assisted Suicide.

Steven E. Olchowski, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS help develop public discussions utilizing open forums, and other means at its disposal, regarding assisted suicide especially physician-assisted suicide.

102-92A

Changes in Billing Procedures.

Magdy Hanna, MD, for the Wayne County Delegation

DISAPPROVED.

103-92A

Support for Barrier-Free Immunizations for Children.

George C. Hill, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS strongly urge the National Vaccine Advisory Committee, the American Medical Association, the American Academy of Pediatrics, and appropriate governmental and elected officials to continue efforts to reduce barriers to immunizations for children and to explore more practical and effective alternatives to these new federally-mandated informed consent procedures, including simplification of patient information brochures; and be it further

RESOLVED: That MSMS urge its members to inform the Michigan Congressional delegation of the negative impact on daily medical practices of burdensome informed consent procedures for childhood immunizations.

Continued on following page

104-92A

Support for the Newborn Hepatitis B Immunization Project Conducted by the Michigan Department of Public Health (MDPH).

George C. Hill, MD, for the Wayne County Delegation

ADOPTED.

RESOLVED: That MSMS offers support to the Michigan Department of Public Health (MDPH) Newborn Hepatitis B Immunization Program and urge its members to utilize the services of this Program whenever medically appropriate.

105-92A

Increased Support for Public Health Programs to Combat HIV Infections and AIDS in Wayne County.

George C. Hill, MD, for the Wayne County Delegation

NO ACTION.

106-92A

Unified Membership.

Steve Olchowski, MD, Wayne

DISAPPROVED.

107-92A

Medical Waste Disposal Costs.

Gerald H. Mandell, MD, for the Wayne County Delegation

ADOPTED AS AMENDED.

RESOLVED: That MSMS work with state government to show the value of enacted legislation, rules and regulations relating to medical waste disposal, in terms of safety and cost; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to ask the Federal government to show the value of enacted legislation, and rules and regulations relating to medical waste disposal, in terms of safety and cost; and be it further

RESOLVED: That if the cost benefit of medical waste disposal rules cannot be proved, that restrictive legislation should be actively reviewed; and be it further

RESOLVED: That if legislation and rules and regulations cannot be shown to be protective of the public's health and cost effective, that MSMS and the AMA seek sunset provisions in such mandates.

108-92A

Health Insurance for Those Who Have None.

Edward E. Elder Jr., MD, Oakland

NO ACTION.

109-92A

23-Hour Hospital Admissions.

Timothy B. Aiken, MD, St. Clair

ADOPTED AS AMENDED.

RESOLVED: That MSMS seek changes in insurance policies related to observation hospital admissions that would permit all physicians, admitting and consulting, to be reimbursed as though the patient were admitted; and be it further

RESOLVED: That MSMS seek information on insurance policies that would make physicians aware of the criteria employed to approve payment for observation hospital admissions.

110-92A

Delays in Medicare Payment.

Timothy B. Aiken, MD, St. Clair

NO ACTION.

111-92A

Support for 911 Services.

Timothy B. Aiken, MD, St. Clair

ADOPTED.

RESOLVED: That MSMS call for the availability of high quality 911 emergency systems in every part of the state.

112-92A

Expert Witness Panel.

Timothy B. Aiken, MD, St. Clair

DISAPPROVED.

113-92A

Office Lab and Imaging.

Magdy M. Hanna, MD, Wayne

ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to support in-office diagnostic testing.

114-92A

Commendation Honoring the County Medical Societies and Senior Citizen Organizations for Implementing Medicare Voluntary Assignment Programs.

Robert D. Allaben, MD, Speaker, MSMS House of Delegates

ADOPTED.

RESOLVED: That MSMS commend the 12 County Medical Societies, and the 24 Michigan Senior Citizens

Organizations for their outstanding efforts to create Medicare Senior Citizen Courtesy Card Programs, which benefit thousands of Michigan's senior citizens.

115-92A

Tort Reform March on Lansing by Doctors.

Edward E. Elder, Jr., MD, for the Oakland County Delegation

NOT ACCEPTED.

116-92A

MSMS Protest NBC Program on International Medical Schools.

Busharat Ahmad, MD, Marquette-Alger

ADOPTED.

RESOLVED: That MSMS lodge a strong protest with NBC and inform Jeff Diamond, executive director of Dateline NBC, that this information is wrong and unacceptable to the physicians in our country; and be it further

RESOLVED: That the president of MSMS, and the chairman of the Board of Directors issue this letter at the earliest possible time.

117-92A

Incorporation of Component County Medical Societies.

Samir M. Ragheb, MD, Macomb

NOT ACCEPTED.

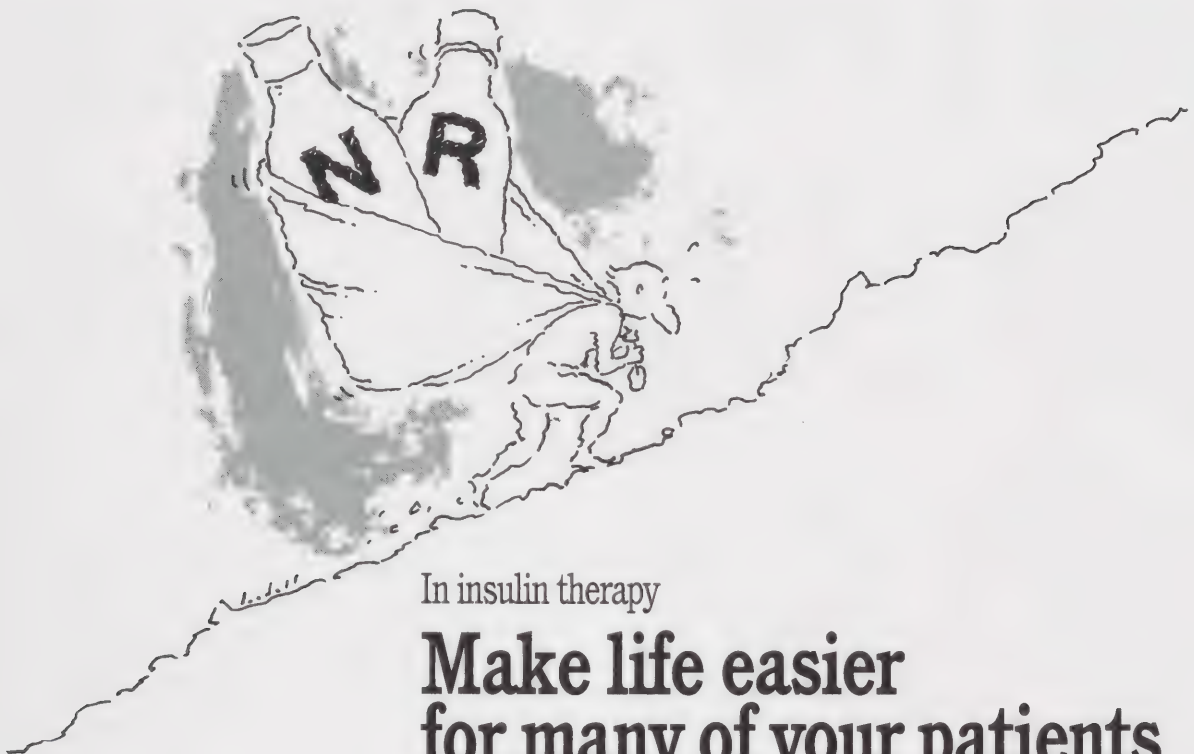
118-92A

AMA Amicus Curiae Brief to Exempt Pension Assets From Bankruptcy.

Gary D. Maynard, MD, for the Board of Directors

ADOPTED.

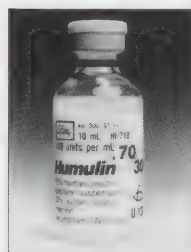
RESOLVED: That the MSMS Delegation to the AMA urge the AMA to consider filing an amicus curiae brief in the U.S. Supreme Court in the case of *Shumate v. Patterson*, supporting the position that ERISA qualified pension plan assets are exempt from creditor claims in bankruptcy.



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Editor's note: Following are excerpts of reports given by the chairmen or presidents of these groups: the Michigan Delegation to the AMA; the MSMS Auxiliary; the MSMS Group Insurance Trust; Physician Service Group, Inc.; Abbott Press; the Physician Review Organization of Michigan; and the Health Education Foundation.

Report of the Michigan Delegation to the American Medical Association

BILLY BEN BAUMANN, MD, CHAIRMAN

The 22-member Michigan Delegation to the AMA is looking forward to a challenging 1992 AMA Annual Meeting, when we will be fielding three candidates for national office. Frank B. Walker, MD, is completing his fourth year on the AMA Board, and is up for re-election. Susan H. Adelman, MD, and Charles C. Vincent, MD, are seeking first terms on the AMA councils on Medical Service and Medical Education, respectively. The campaigns of all three candidates are well underway. Each has been making personal contacts with AMA delegates around the country. Members of the Michigan Delegation have committed to making contacts for the candidates, and are pleased and proud to be backing all three. MSMS is preparing campaign literature and planning its annual champagne reception for the annual meeting.

Highlights of the past year were the AMA Annual Meeting June 23-26, 1991, in Chicago, and the AMA Interim Meeting December 8-12, 1991, in Las Vegas, Nevada.

At the June meeting, delegates elevated Billy Ben Baumann, MD, from vice chairman to chairman of the Delegation, succeeding Robert D. Burton, MD. They elected Robert D. Allaben, MD, as vice chairman. Cathy O. Blight, MD, was continued as secretary/treasurer. MSMS Past President Donald K. Crandall, MD, lost his bid for AMA House of Delegates vice speaker. Thomas C. Payne, MD, and Busharat Ahmad, MD, served on House reference committees. Rhoda M. Poswner, MD, was elected chairman of the AMA Women Physicians Caucus, and Doctor Adelman was chosen chairman-elect of the Surgical Caucus.

The Michigan Delegation introduced 10 resolutions at the June meeting. Four of the 10 Michigan resolutions were adopted outright, one adopted as amended, and another adopted in substitute form. Those resolutions called for the AMA to:

- Request that the Health Care Financing Administration, while instituting computer billing, also preserve manual billing without penalties or disincentives.
- Seek third-party payor reimbursement for physicians who care for patients in observation or short-stay units.
- Ask HCFA to require professional review organizations to use specialty reviewers, or, if none is available, to contract with outside physician specialists to provide true peer review.

- Pursue with peer review organizations a careful definition of an adverse patient event; a determination of the event's avoidability, and a determination of whether or not the event demonstrates a pattern of inappropriate physician/institutional behavior.
- Encourage regulatory agencies, including the FDA, to mandate labeling of all foods containing even small amounts of man-made L-glutamic acids, so people can avoid the substance if they want to.
- Encourage medical school admissions officers and residency program directors to select applicants on the basis of merit alone, without consideration of an ethnic name as a deterrent.

Two resolutions — seeking legislation to indemnify physicians for care of medically indigent or underinsured patients, and seeking support of federal nondiscriminatory legislation for international medical graduates — were referred to the AMA Board.

At the Interim Meeting in December, the Delegation introduced seven resolutions. Three of the seven were adopted in some form, while two were referred to the Board, and two were not adopted.

The three adopted called for:

- Equal access in hospitals for physically challenged physicians,
- The AMA to encourage legislation providing insurance for adopted children,
- A differentiation between AMA House policy and AMA ethical opinions.

Referred to the Board were resolutions calling for the AMA to vigorously pursue a simplified medical billing system for all third party payors, and for the AMA to undertake educational measures for physicians about the true addictive nature of benzodiazepines. Resolutions on curbside recycling and bottle/can recycling were not adopted.

In addition, the Delegation furthered by letter eight other measures adopted by this House last year. They included calls for the AMA to continue its Advisory Committee on International Medical Graduates, for the AMA to appoint only members of both their state medical associations and the AMA to national medical policy committees, and for the AMA to recognize the Genesee County Medical Society on its 150th year.

Members of the Michigan Delegation to the AMA are:

Delegates: Susan H. Adelman, MD, Southfield; Busharat Ahmad, MD, Marquette; Robert D. Allaben, MD, Detroit; Billy B. Baumann, MD, Pontiac; Robert D. Burton, MD, and R. Jack Chase, MD, both of Grand Rapids; Donald K. Crandall, MD, Muskegon; Gerald H. Mandell, MD, Detroit; Robert E. Paxton, MD, Fremont; Thomas C. Payne, MD, East Lansing; and Louis R. Zako, MD, Dearborn Heights.

Alternate delegates, (in order of seniority): Robert S. Black, MD, Detroit; Rhoda M. Powsner, MD, Detroit; Cathy O. Blight, MD, Flint; B. David Wilson, MD, Kalamazoo; Peter A. Duhamel, MD, Rochester; Marguerite R. Shearer, MD, Ann Arbor; Willard S. Stawski, MD, Grand Rapids; Charles C. Vincent, MD, Detroit; John W. Hall, MD, Petoskey; Gilbert B. Bluhm, MD, Troy, and a resident to be named.

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COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

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INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain. **CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone. **WARNINGS:** **Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression. **Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS:** **Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. **Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. **Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anxiolytic agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Use in Pregnancy:** Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. **Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. **OVERDOSAGE:** **Acetaminophen Signs and Symptoms:** In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemia, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised March 1992

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Report of the Michigan State Medical Society Auxiliary

LOIS DUHAMEL, PRESIDENT

As the practice of medicine is constantly changing in today's world, so too is the Auxiliary in a constant state of change. No longer are we just a social group acting as a support group for the medical family. We are actively working with and for the medical societies on the national, state and county levels, in the legislative arena, sponsoring health-related programs (on drug abuse, teenage pregnancy, alcoholism, AIDS, etc.), fundraising for medical education, and numerous other health-related projects.

■ Last year, Michigan State Medical Society Auxiliary raised \$40,450 for AMA-ERF. This is in addition to all the funds raised at the county level by county auxiliaries for local projects.

■ The video, "MEDICINE IN JEOPARDY," developed by the Michigan State Medical Society Auxiliary three years ago, has been shown by Auxilians to groups of people throughout the state. As a result, thousands of our yellow post cards were sent to the Governor and legislators demanding liability reform.

■ During last year's Health-O-Ramas, 14 Auxilian volunteers showed the video at 22 sites over a four-week period and collected over 4,200 yellow postcards. At the present time, we are actively involved in showing the second video, "JUSTICE OR JEOPARDY," produced by the Michigan Medical Liability Reform Coalition.

■ Another major emphasis of Michigan Auxilians is their involvement in the letter writing campaign targeting members of the Michigan House urging their support and passage of the medical liability bills now in committee, HB5434 and HB5435.

■ In the political arena, the Auxiliary is becoming increasingly informed on issues and candidates, especially as they affect the practice of medicine.

I have observed that in many county medical societies, the physicians who are most active have spouses who are not members of the Auxiliary. The reverse is also true. Many of our most active Auxilians have physician spouses who pay dues, but are not involved in their local medical societies. Granted both organizations need and appreciate the financial support of inactive members, but we need more than their money. We also need their active participation. I would like especially to encourage the spouses of female physicians to become actively involved in our mission, since all physicians' spouses share the same problems. Most spouses of female physicians are professionals. The Legislative Committee of the Auxiliary is an ideal place for male auxiliaries to become involved, as Michigan's poor liability climate is affecting all businesses today.

The medical society and Auxiliary must work together in a true partnership if we are to meet the challenges facing medicine in the '90s. The Medical Auxiliary has the potential to be a powerhouse for organized medicine. Help us to unleash that potential.

Report of the MSMS Group Insurance Trust

B. DAVID WILSON, MD, CHAIRMAN

The Group Insurance Trustees direct the MSMS-sponsored insurance programs. These programs include the Blue Cross Blue Shield health insurance plan, the Delta Dental program and other sponsored insurance programs, such as the disability income insurance, term life insurance programs, business over-



Lois Duhamel, president of the MSMS Auxiliary presents her report on auxiliary activities to members of the House of Delegates.

head and expense programs marketed through the Stratton-Cheeseman Walsh Agency.

The MSMS health insurance plan continues to grow with an annualized premium of approximately \$22 million and has over 7,000 participants. Every year since MSMS took over the direct administration of the health insurance plan, there has been growth in the number of participants of the plan. A significant development in 1991 was the introduction of true group programs for MSMS members. MSMS can now market all the group options available through Blue Cross Blue Shield.

The group option has shown significant increase in membership, due to the ability to tailor programs for the needs of larger medical groups. Additionally, the MSMS Group Insurance Trust developed a flexible spending plan to be used in conjunction with the group program in order to fund out-of-pocket expenses with pre-tax dollars. The Delta Dental program continues to have significant growth in the number of subscribers. Since its introduction three years ago, the plan has grown to one million dollars in premiums and has approximately 900 contracts. In the last two years, the plan's premiums have not increased and it appears in 1992, the premiums will once again remain stable. The MSMS Delta Dental program was the first free-standing association plan introduced in Michigan and is currently being replicated by numerous other associations. Other developments in the MSMS-sponsored insurance programs have been the revamping of the disability income program through the Provident Insurance Companies. This program now provides significant advantages to MSMS members seeking disability income insurance. Also in 1991, the Trustees approved a new rate structure for the term life insurance program. This rate structure will favor younger physicians and the target market will be for new members seeking inexpensive life insurance. In addition to these two programs, MSMS Group Insurance Trust agreed to jointly sponsor with the American Medical Association, an HIV Policy. The first mailings for this program have gone out and members can take advantage of this either directly through the AMA or through MSMS. Currently, plans are underway to offer a long-term care product, as well as several other improvements to existing programs. It is apparent from the response of the members using MSMS-sponsored programs, the direct administration by MSMS represents a major improvement over members trying to deal directly with insurance agencies or with the insurers. The Trustees believe as experience is gained in the insurance programs, there are numerous other opportunities where MSMS can provide significant member benefits through the Group Insurance Trust.

Continued on following page

Report of the Physician Service Group, Inc.

BILLY BEN BAUMANN, MD, PRESIDENT

Physician Service Group continues to provide a broad spectrum of products and services to the membership of the Michigan State Medical Society. Three areas of concentration for PSG are insurance administration, specialty society staffing, and endorsed services. Due to these services, the vast majority of MSMS members have contact with PSG during the year. PSG continues to research and focus on the development of programs adding value to the MSMS membership. Each service is administered by the organization in order to assure members using these programs of the highest quality of service. The Specialty Society Administrative Program continues to provide staffing services to 14 specialty societies and other medical organizations. This area of PSG plans and staffs approximately 70 different meetings per year, including board meetings and major scientific educational meetings. Efforts have been made this year to assist in integrating the communications between the Michigan State Medical Society and the specialty societies. It is important for the specialty societies to understand the directions and concerns of the Michigan State Medical Society, as well as MSMS receiving input on issues from each of the specialty organizations administered by PSG. Also, this area continues to seek opportunities to provide additional services to specialty groups and other organizations.

PSG's Endorsed Service Program continues to grow each year. It is the policy of the PSG Board to endorse only a small

number of services the Board feels are of direct benefit to physicians in their practices. Also, PSG maintains a list of individuals providing specific services useful to physicians at various times in their careers. Many physicians are accustomed to calling PSG for recommendations in regards to services such as selling practices, contract evaluations, and other types of services physicians may need in their practices.

The last section of PSG is in the administration of the MSMS-sponsored insurance programs. During the year, PSG has directed its marketing efforts to the MSMS health insurance programs, as well as Delta Dental programs. In this area, PSG bills and accounts for over \$22 million in premiums of the Blue Cross Blue Shield program, along with the one million dollars of premiums from the Delta Dental program. PSG

provides direct customer service to these programs and deals with approximately 1,000 phone calls per month from members, their families and employees.

Physician Service Group continues to make a substantial financial contribution to the Michigan State Medical Society through the Physician Holding Company, Inc., in addition to its strong emphasis in providing services to add to the value of the MSMS membership.

Report on the 1991 Activities of Abbott Press

BILLY BEN BAUMANN, MD, CHAIRMAN

In November of 1991, MSMS created a wholly-owned, for-profit, printing company, under the Physician Holding Com-

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pany. This action was taken due to the large amount of printing MSMS has done over the last few years, including *Medigram* and all other brochures, letterhead and informational materials sent to its members. As Abbott Press began its operations, it was apparent there was a significant additional market for its services. Currently, Abbott is providing printing to numerous other associations, county medical societies, individual physicians, and other groups interested in high quality printing.

The goal of Abbott Press is to allow MSMS to increase its communication to its members, while not substantially increasing the cost for these services. By providing printing to other organizations and associations, it is hoped not only will MSMS benefit, but other organizations will benefit from Abbott's ability to provide high quality printing for reasonable rates.

Since Abbott Press is less than six-months-old, it is not possible to give definitive information regarding the finances, or its potential market. However, within the first six months, Abbott is running at better than "break even" financially.

Report of the Physician Review Organization of Michigan, Inc.

ROBERT C. PROPHATER, SR., MD, PRESIDENT

The Board of Directors held a long-range planning session in August 1991, facilitated by Bruce Balfe, AMA VP for Strategic Planning. This was very productive and provided focus for the future direction of PROM. During this session the PROM Board approved the following mission statement:

The Mission of PROM is to assure high quality medical care through independent, expert physician peer review based on credible standards of care, and to enhance medical knowledge and practice through ongoing research and education.

The PROM Board of Directors view the major role of PROM as maintaining the highest integrity as an organization for independent objective third party review services.


The past year has been one of transition for the organization. The Board of Directors approved the hiring of a full-time director in April 1991. The director's initial charge was to begin a process to broaden the operational base of PROM. This led to review for third party administrators and expansion of hospital review, credentialing activities.

PROM staff met with the BCBSM Contract Advisory committee to discuss the role of PROM in the new provider contract and its ability to perform. PROM continues to provide appellate services to Blue Cross and Blue Shield of Michigan, other insurers and has completed more than 16,000 reviews. PROM has submitted a proposal to expand services to BCBSM by providing arbitration services under the new Physician Provider Agreement.

PROM staff has been working in cooperation with the MSMS Worker's Compensation Task Force involving an appellate process to the system. An opportunity to bring some standardization to the process involving many carriers.

PROM efforts to seek reviewers has focused upon the specialty societies, i.e., Michigan Psychiatry Society, Michigan Academy of Physical Medicine and Rehabilitation. PROM has continued to seek reviewers who are in active practice and board certified within their respective specialty.

Continued on page 29



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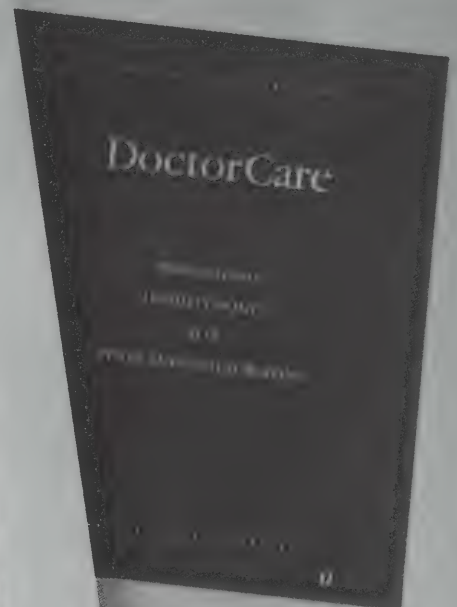
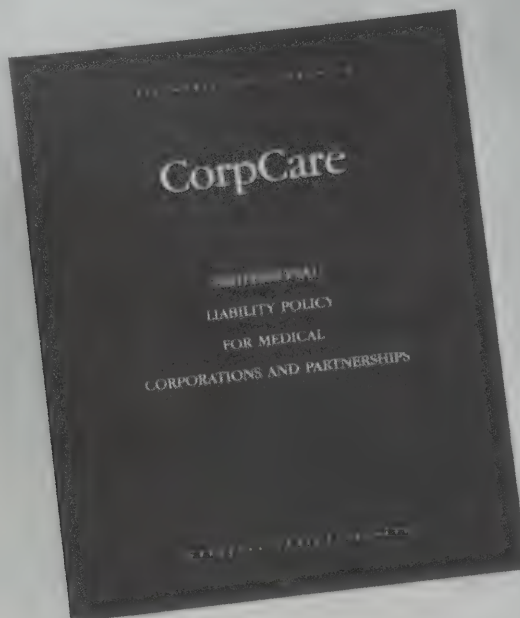
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Continued from page 27

Medical peer review, credentialing and privileging issues are difficult to address in today's health care environment. Most hospitals address these issues through their medical staff committee structure. PROM staff has initiated mailings to hospital CEOs and Chiefs of Staff to inform them of the services available from PROM. Our reviews may complement the peer review efforts of a medical staff through an external objective review, validating the ongoing efforts and may be useful as an independent reviewer of the parameters of practice.

Report of the Health Education Foundation

ROBERT E. PAXTON, MD, PRESIDENT

The Health Education Foundation Board of Trustees met on January 9, April 25, and September 25, 1991, and January 14, 1992.

The Health Education Foundation continues to work towards its goal of increasing the physician awareness level of the Foundation, its activities and its mission and thereby increase the contributions made to the Foundation. This past year, the Foundation regrettably accepted the resignation of Louis Zako, MD, from the Board. The Board of Trustees appreciates the time and enthusiasm given by Doctor Zako to the Foundation. We have nominated John Hall, MD, to replace Doctor Zako on the Foundation Board. As briefly as possible, let me address specific items regarding the past year and the future of the Foundation.

1. *Financial Matters:* The Foundation continues to maintain responsibility for its own investment portfolio and those of the Danto Memorial Fund, Bruce Fellowship Fund, and the Impaired Physician Loan Fund. Mr. Tom McGann, vice president of Manufacturers National Bank, provides advice and support to the Foundation regarding our investment portfolios.

2. *Grant Activity:* The Board of Trustees awarded the following grants in 1991:

Michigan Health Council - annual support of \$1,000

Area Agencies on Aging - \$4,500 for volunteer training within the Medicare/Medicaid Assistance Program.

Webberville High School - \$3,500 for the purchase of CPR mannequins to teach CPR to junior and high school students.

Wayne State University Institute of Gerontology - \$1,000 for health care professionals program on issues of the aging.

Council of MI Foundations - Michigan AIDS Fund - \$2,000

Bruce Fund - University of Michigan Pediatric Department - \$360 for educational materials

Bruce Fund - United Way of Saginaw - \$150 for educational materials

3. *Impaired Physician Loan Fund:* One loan to an impaired physician was made in 1991. Outstanding loans are being scrutinized and tracked on a regular basis. As always, the primary purpose of the impaired physician loan fund is to provide monies to assist with rehabilitation, not personal, expenses.

4. *Fund-Raising Activities:* The Foundation represents a remarkable opportunity for the medical profession to accomplish non-self-serving, altruistic community service goals, but only if the corpus of the Foundation attains a size to make the Foundation efforts truly productive. Fund-raising is therefore an essential function and could be termed the "life-blood" of the Foundation. A member solicitation included with the MSMS dues billing resulted in \$1,325. A cruise raffle was held in 1991 realizing a break-even situation for the Foundation, but

achieved a public recognition result of substantial value for further efforts. In 1991, the challenge presented to the MSMS Board of Directors resulted in \$3,025. We are very appreciative of your personal support to our Foundation. Your support is the most important of all if we are to have true success in our fund-raising efforts.

A golf outing for MSMS members and friends at Sylvan TreeTops Resort is scheduled for August 20 - 23, 1992, with proceeds going to the Foundation. Another cruise or Club Med raffle is also being planned. Discussions with county medical societies for joint fund-raising efforts is being considered, as well as planned giving efforts on behalf of the Foundation.

The Health Education Foundation Board of Trustees greatly appreciates the support provided by the MSMS Board of Directors, both financially and organizationally. In 1992, the primary objective of the Foundation Board will be the enlargement of the assets of the Foundation by fund-raising within the physician community. If sufficient physician support is achieved, fund-raising will be pursued in non-medical circles as well. Foundation support is needed for many worthy projects which will fulfill both Foundation and MSMS goals for the advancement of the cause of improved health of our statewide community.

Members of the Board of Trustees are: Bruce W. Ambrose; Nancy Crandall; Henry M. Domzalski, MD; John W. Hall, MD; William E. Madigan; Richard J. McMurray, MD; Robert E. Paxton, MD; Suzanne H. Pederson; Arthur L. Tuuri, MD; Rev. Bertram W. Vermeulen; and Richard D. Weber.

MSMS has enjoyed a successful year

By Robert D. Burton, MD

Where do you begin on a smorgasbord as big as the past year? Where do you take the first bite? What a year it has been.

There are few places in Michigan where I have not talked during the past year, and I've enjoyed every place I have visited.

I've learned as much about the geography of our beautiful state in the past year as I have in all of those preceding.

From the rolling fruitland in southwest Michigan, to the flat sugar beet farms in the Thumb, from the high-density, high-energy cities of southeast Michigan, to the high mountains and high trees of the western Upper Peninsula.

The one constant thing I have observed in each of these places is the dedication our members have for their patients.

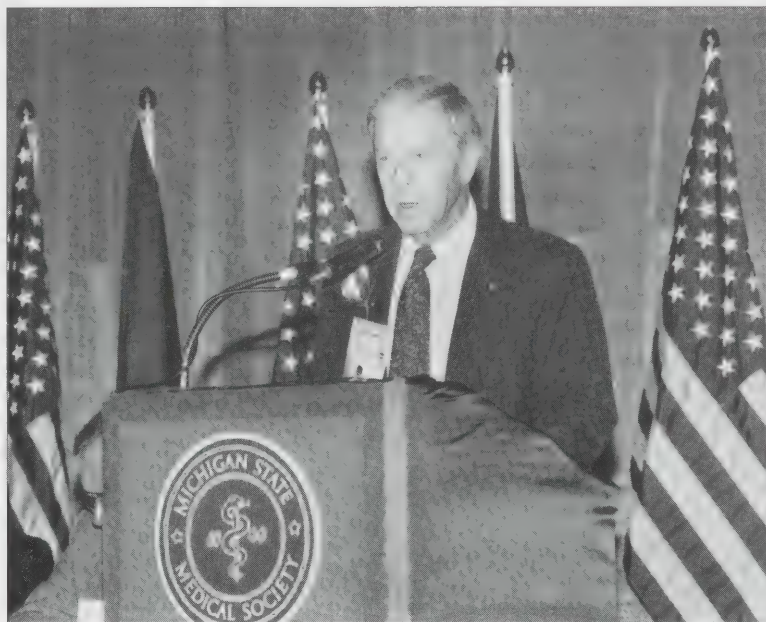
We physicians want good things for our patients. We want to work for positive change. We want to succeed, not only for ourselves and our families, but for our millions and millions of patients.

During my year as your president we have worked for change. We have tried hard to succeed.

But a year is such a short time in the life of change. It takes a lot of time and energy to succeed.

How do we achieve success? What is success?

I have developed my own defini-



tion of success. It comes from paraphrasing a line in a book called "Polar Star." It is the latest book by the author of "Gorky Park."

In it, one of his characters is a former KGB agent. He now works in the bowels of a huge fish-canning factory ship in the Bering Sea off Alaska. His name is Arkady Renko.

During a respite on the "slime line" where they clean the fish, Renko tells his comrades that to him, "happiness is the maximum agreement of reality and desire." And with a job like he had, he probably wasn't a very happy fellow.

But I liked this line and changed it to suit our purposes. I like to say "success is the maximum agreement of reality and desire."

So, using this definition of success, I believe MSMS has enjoyed a successful year. We worked to match our desires with reality on many issues facing physicians. We have seen successes.

Four key issues

Let's look quickly at four issues. They are the ones from my inaugural one year ago. If you were here that day, you might recall they were "something old, something new, something borrowed, something blue."

Professional liability

Something old was professional liability. We have had some success, so far. But the

battle is far from over. We have built a strong coalition. Our bills have passed the Senate. They've been introduced into the House with strong bi-partisan support. Now we are working on a process to get them either onto the floor of the House for a vote or into a conference committee of the two chambers. We need a continued outpouring of energy from you to achieve total success. Our desires are just. We can force the reality if everyone does their part by holding their legislators accountable. We can succeed. And succeed we must, for our patients and our successors.

Turf battles

Something new was turf battles. Again we have enjoyed much success, so far. We have stood up to protect our patients from unqualified practitioners, from chiropractors, from optometrists and nurse practitioners, all who want to expand their scopes of practice be-

yond their education and training. Again, our desires are just. But the reality is that — over and over again — we will be assailed by those who want to be medical doctors without going to medical school. In the coming years, we will continue to be forced to fight to protect our patients.

Blue Shield of Michigan. We fought hard for changes, through the Physician Contract Advisory Committee and with the help of state legislators. MSMS sought a fee increase, and since April 1st, you have seen a payment increase for most services, five percent statewide and 7.5 percent in Southeast Michigan.

things take time. The process requires patience. And it requires a balance, it requires the maximum agreement of reality and desire.

These are difficult times for medicine. The forces of divisiveness are out there, always trying to split the unity that makes us strong. Be on guard. Keep a watchful eye.

I hope we have succeeded in hearing the voice of the minority in all of our deliberations. And I hope I have represented you well in media and to the public.

And finally, thank you for this wonderful honor, for this opportunity to do your wishes.

Personally, I am happy. We have succeeded. At least according to my own definition. From the beginning we have tried to reach the maximum agreement of reality and desire. It seems to have worked. We've enjoyed much success. I hope MSMS can continue to do so for a long time into the future. ■



Ethics

Something borrowed was ethics. Here is a wonderful example of balancing reality and desire. We adopted a policy against physician assisted suicide, yet we have taken the lead in creating a forum to discuss the issue with representatives of all sides, all extremes. We know this issue is far from settled, so we are working to match society's desires with its reality. What a rewarding and honorable thing to do. This makes me very proud of our medical society.

The Blues

And finally, something blue. Again, our desires were just. We have made progress with Blue Cross

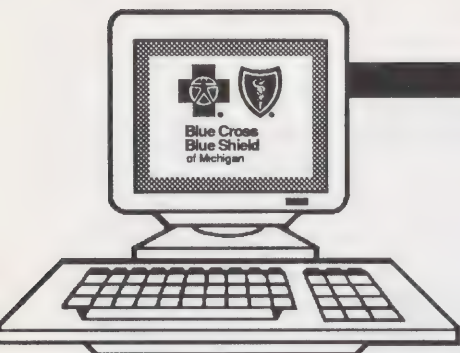
We also improved the "medical necessity" determination. We improved "prior authorization" rules. And very importantly, we got the Blues to agree to use an independent researcher to investigate the 40 percent reimbursement differential between Michigan and surrounding states.

Obviously, not everything is solved, nor were we as successful in every battle as we wanted to be. But



Above left: MSMS Immediate Past President Robert D. Burton, MD, (right) accepts his past president's pin from MSMS Board Chairman Jack L. Barry, MD.

Above: MSMS Immediate Past President Robert D. Burton, MD, (right) takes a moment to celebrate at the MSMS House of Delegates meeting with his wife, Nella, (far left) and Mrs. McMurray, (middle) wife of MSMS past president Richard L. McMurray, MD.



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- Allows for quick patient recall
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Uses the expanded power of a hard disk-equipped personal computer to fully automate billing and business management capabilities:

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- Generates referral reports
- Generates additional financial and management reports



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■ MSMS AWARDS ■



Thirty-four Michigan physicians were presented an award for 50 years of service.

Fifty-Year Awards

Fifty-year awards were presented to the following:

E. Bryce Alpern, MD, Bloomfield Hills, MI
 Dean R. Asselin, MD, St. Joseph, MI
 William C. Baum, MD, Brevard, NC
 Carl A. Benz, MD, Adrian, MI
 Vernon B. Blaha, MD, Port Charlotte, FL
 Andrew G. Brown, MD, Birmingham, MI
 Arnold L. Brown, MD, W. Bloomfield, MI
 Frederick W. Brown, MD, Lansing, MI
 Edwin L. Bruer, MD, Southgate, MI
 Donald I. Bryan, MD, Dearborn, MI
 Leo W. Bunce, MD, Trufant, MI
 Robert B. Burrell, MD, Kalamazoo, MI
 F.M. Burroughs, Jr., MD, Forrest, MS
 Joseph L. Cahalan, MD, Southgate, MI
 Lee Carrick, MD, Naples, FL
 Ensign E. Clyde, MD, Plymouth, MI
 Lewis Cohen, MD, Southfield, MI
 Edward D. Conner, MD, Pisgah Forest, NC
 Alan R. Crain, MD, Southfield, MI
 Robert R. Crissey, MD, Hendersonville, NC
 Richard K. Currier, MD, Long Key FL
 Byrne M. Daly, MD, Jackson, MI
 Donald L. Davidson, MD, Marenisco, MI
 Ralph E. Dawson, MD, Flint, MI
 Harold, E. DePree, Kalamazoo, MI
 J. William Derr, MD, Pleasant Ridge, MI
 Quincey C. Fan, MD, Flint, MI

James M. Fisher, MD, Grosse Pointe, MI
 Thomas W. Fochtman, MD, Grand Rapids, MI
 Ralph M. Fox, MD, Venice, FL
 Paul L. Fraiberg, MD, West Bloomfield, MI
 G.C. Frederickson, MD, Rochester, MI
 Arthur F. Geis, MD, Kalamazoo, MI
 John R. Glover, Sr., MD, Livonia, MI
 Aubrey Goldman, MD, Birmingham, MI
 Stephen V. Goryl, MD, Detroit, MI
 Nelson W. Green, MD, Deltona, FL
 Alexander Grinstein, MD, Birmingham, MI
 Leonard Haking, MD, Birmingham, MI
 Dorin L. Hinerman, MD, Ann Arbor, MI
 Jason Hodges, MD, Harrisville, MI
 David B. Johnson, MD, Okemos, MI
 William L. Johnston, MD, Grand Rapids, MI
 Dale L. Kessler, MD, Grand Rapids, MI
 Sander P. Klein, MD, Birmingham, MI
 Chester S. Koop, MD, Frankfort, MI
 Edward C. Lake, MD, Empire, MI
 Philip J. Laux, MD, Berkley, MI
 Samuel I. Lerman, MD, Canton Twp, MI
 James W. Lyons, MD, Beulah, MI
 Thomas B. Mackie, MD, St. Ste. Marie, MI
 Leslie Mandel, MD, Southfield, MI
 Peter A. Martin, MD, Lake Orion, MI
 Brooker L. Masters, MD, Fremont, MI
 Victor S. Mateskon, MD, Indian River, MI
 French H. McCain, MD, Bloomfield Hills, MI
 Leland R. McElmurry, MD, Eaton Rapids, MI
 Morris Medalie, MD, Dearborn, MI

John S. Metes, MD, Detroit, MI
 William R. Miller, MD, Farmington Hills, MI
 George Mogill, MD, Royal Oak, MI
 Coleman Mopper, MD, Warren, MI
 William C. Noshay, MD, Waterford, MI
 Beverly C. Payne, MD, Ann Arbor, MI
 Charles F. Payton, MD, Tucson, AZ
 George H. Phillips, MD, Jackson, MI
 Joseph L. Ponka, MD, West Bloomfield, MI
 Millard Posthuma, MD, Macomb, IL
 Marcia L. Potter, MD, Ypsilanti, MI
 David S. Randall, MD, Grosse Ile, MI
 Stephen H. Randolph, MD, Edenville, MI
 Richard L. Rapport, MD, Flint, MI
 Alva D. Rush, MD, Birmingham, MI
 George S. Sayre, MD, Ypsilanti, MI
 G.L. Schaiberger, Sr., MD, Green Valley, AZ
 Howard J. Schaubel, MD, Grand Rapids, MI
 Frederick C. Schwartz, MD, Brutus, MI
 Eugene S. Sevensma, MD, Grand Rapids, MI
 Maurice Tatelman, MD, Scottsdale, AZ
 Douglas H. Taylor, MD, Berrien Springs, MI
 Arthur L. Thompson, MD, Detroit, MI
 Chester J. Ujda, MD, Wayne MI
 F. Valdmans, MD, Grand Rapids, MI
 Douglas L. Wake, MD, Pompano Beach, FL
 Carl H. Wallman, MD, Stuart, FL
 Vernon L. Weeks, MD, Monroe, MI
 John D. Whitehouse, MD, Grand Rapids, MI
 Douglas J. Wood, MD, Warren, MI
 Ralph Worthington, MD, Lansing, MI

Frederick and Besse Moulton Plessner Memorial

This award is presented by the MSMS Board of Directors to a rural physician who "best exemplifies the practice and ethics of a rural country practitioner. This year's recipient was:

Joseph F. Baron, MD, Laurium, MI

Flag Award

This award was presented to the following presidents of statewide non-medical organizations:

Appa Rao Mukkamala, MD, President, American Association of Physicians of India, Flint, MI
 Vainutis K. Vaitkevicius, MD, President, Michigan Cancer Foundation, Detroit, MI

National President Award

This award was presented to the following for their service as presidents of national medical organizations:

Brooks F. Bock, MD, President, Association of Academic Chairs of Emergency Medicine, Detroit, MI
 William F. Chandler, MD, President, Congress of Neurological Surgeons, Ann Arbor, MI

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W. Patrick Mazier, MD, President, American Society of Colon and Rectal Surgeons, *Grand Rapids*, MI
 Norman W. Thompson, MD, President, International Association of Endocrine Surgeons, *Ann Arbor*, MI
 Peter A. Ward, MD, President, United States and Canadian Academy of Pathology, *Ann Arbor*, MI
 Richard A. Wetzel, MD, President, American College of Nuclear Medicine, *Royal Oak*, MI

Community Service Award

This award was presented to the following physicians who were nominated by their county medical societies for special contributions to their community and/or humanity:

J. Max Busard, MD, Muskegon County Medical Society, *Muskegon*, MI
 J. Michael Coyne, MD, Marquette-Alger County Medical Society, *Marquette*, MI
 Armin T. Franke, MD, St. Clair County

Medical Society, *Port Huron*, MI
 Donald G. May, MD, Kalamazoo Academy of Medicine, *Kalamazoo*, MI
 Richard D. Mudd, MD, Saginaw County Medical Society, *Saginaw*, MI
 Marigowda Nagaraju, MD, Genesee County Medical Society, *Flint*, MI
 William E. Sprague, MD, Kent County Medical Society, *Grand Rapids*, MI
 Scott W. Woods, MD, Washtenaw County Medical Society, *Ypsilanti*, MI

House of Delegates Certificate of Appreciation

This award, given to MSMS members for their past service on the Michigan Delegation to the American Medical Association, was presented to:

Pino D. Colone, Student Delegate, *Flint*, MI
 Fernando C. Gomez, MD, Resident Physician Delegate, *Royal Oak*, MI
 Gary D. Maynard, MD, Alternate Delegate, *Kalamazoo*, MI



H. Richard Henderson, MD, (at podium) addressed delegates, alternate delegates and guests at the MSMS House of Delegates meeting after being presented with a Presidential Citation from outgoing MSMS President Robert D. Burton, MD.

Presidential Citation

This award, presented to physicians or lay persons who have made an outstanding contribution to medicine in the state, was presented to the following physician as Founder, President and Co-medical Director of Project HOW (Health on Wheels):

H. Richard Henderson, MD, *Farmington Hills*, MI

The 1992 House of Delegates elected the following MSMS officers and directors, as well as delegates and alternates to the American Medical Association.

Officers (to the 1993 Annual Session)

President
 Thomas C. Payne, MD, *East Lansing*
 President-elect
 Gilbert B. Bluhm, MD, *Troy*
 Secretary
 Thomas R. Berglund, MD, *Portage*
 Assistant Secretary
 Earl G. Moehn, MD, *Mt. Clemens*
 Treasurer
 Billy Ben Baumann, MD, *Pontiac*
 Assistant Treasurer
 B. David Wilson, MD, *Kalamazoo*
 Speaker
 Robert D. Allaben, MD, *Detroit*
 Vice-Speaker
 Gary D. Maynard, MD, *Kalamazoo*

District Directors (to the 1995 Annual Session)

1st District
 Richard P. Horsch, MD, *Farmington Hills*
 1st District
 Charles C. Vincent, MD, *Detroit*
 4th District
 David J. Millard, MD, *Paw Paw*
 4th District
 B. David Wilson, MD
 5th District
 R. Jack Chase, MD, *Grand Rapids*
 6th District
 Cathy O. Blight, MD, *Flint*
 14th District
 Rhoda Powsner, MD, *Ann Arbor*

Delegates to the AMA (to the 1994 Annual Session)

Busharat Ahmad, MD, *Marquette*
 Robert D. Allaben, MD, *Detroit*
 Billy Ben Baumann, MD, *Pontiac*
 R. Jack Chase, MD, *Grand Rapids*
 Louis R. Zako, MD, *Dearborn Heights*

Alternate Delegates to the AMA (in order of seniority to the 1994 Annual Session)

Rhoda M. Powsner, MD, *Ann Arbor*
 B. David Wilson, MD, *Kalamazoo*
 Charles C. Vincent, MD, *Detroit*
 John W. Hall, MD, *Petoskey*
 Fernando Gomez, MD, *Royal Oak*, Resident (term ending 1993)

LIFE MEMBERSHIPS

A life member is any physician who has maintained an active membership in good standing for 25 years in any one or more constituent state societies of the American Medical Association with any five years in Michigan. Those recognized at the 1992 MSMS House of Delegates include:

Bay - John L. Langin, MD; Robert C. Prophater, MD

Calhoun - Frank L. Lanuti, MD; William L. Van Arsdale, MD

Genesee - Lewis E. Simoni, MD

Ingham - Edward B. Leverich, MD; Andy L. Messenger, MD

Kalamazoo - James C. Breneman, MD; William A. Decker, MD; Robert H. Grekin, MD

Kent - Orval McKay, MD; Carl H. Moberg, MD; Marshall Pattullo, MD; Bernard H. Siebers, MD

Macomb - Victor Curatolo, MD; Edith V. Ravasz, MD; William U. Reidt, MD

Manistee - Donald N. Schwing, MD

Mason - John R. Carney, MD

Monroe - Charles E. Black

Muskegon - Richard Kisloy

Oakland - Franz S. Bauer, MD; Veldora F. Clunas, MD; Gerald G. Durak, MD; Feridian Guroi, MD; Michael C. Kozonis, MD; James M. Lawson, MD; Thomas S. McInerney, MD; Elmer J. Mueller, MD; George Ritter, MD; Frederick F. Shevin, MD; Richard E. Straith, MD; Robert K. Wise, MD

Saginaw - Kenneth Repola, MD; John L. Shek, MD

St. Clair - Nicholas Douvas, MD

Washtenaw - Johan W. Eliot, MD; Everett R. Harrell, MD; James A. McLean, MD; Robert Rapp, MD; Donald C. Smith, MD

Wayne - David H. Barker, MD; Robert W. Black, MD; Rosemarie Blosen, MD; Mike J. Brennan, MD; Arnold Charnley, MD; Vehbi Dayioglu, MD; Henry Domzalski, MD; Paul J. Dzul, MD; John Fennessey, MD; Fathy S. Gabriel, MD; Louis Garilepy, MD; Benjamin Haddad, MD; Hugh W. Henderson, MD; M. Colton Hutchins, MD; Napoleon Imperio, MD; Richard S. Kamil, MD; Harold Krevsky, MD; An-

drew Mann, MD; Gordon Manson, MD; Harry Mauthe, MD; Vytautas Mileris, MD; Richard Royer, MD; Benjamin Schwimmer, MD; Marrion Scott, MD; Zwi Steiger, MD; Joy Y. Wang, MD

RETIRED MEMBERSHIPS

Retired members are physicians who have maintained membership for five years in the component medical society and are retired from active practice. Those recognized at the 1992 MSMS House of Delegates include:

Alpena - Frederick O' Dell, MD

Barry - Douglas Castleman, MD

Barrien - William C. Bock, MD; Harshod K. Doshi, MD; David W. Hills, MD; Frank V. Linn, MD; John T. McLelland, MD

Calhoun - Alfred Hamady, MD; Herbert E. Humphry, MD; Robert D. Sparks, MD

Genesee - C. Arch Brown, MD; Gerald G. Cole, MD; David E. Congdon, MD; Frank W. Cook, MD; Jack Grommons, MD; Thomas C. Lindman, MD; Edwin Smith, MD; Vernon C. Urich, MD

Grand Traverse - Johnson K. Wright, MD; John Y. Young, MD

Gratiot - Edwin G. Meyer, MD

Ingham - Donald Aiken, MD; Harold E. Bowman, MD; Beverly A. Collier, MD; Richrd L. Collier, MD; Martin Kozachick, MD; Paul T. Niland, MD; Charles K. Wortley, MD; John H. Wylie, MD

Ionia-Montcalm - Frank Merchum, MD

Isabella-Clare - Frank D. Johnson, MD; Robert R. Yoder, MD

Jackson - Robert C. Buslepp, MD; Arthur S. Haight, MD

Kalamazoo - Charles R. Beyerlein, MD; Ervin Novak, MD; Richard A. Proos, MD

Kent - L. Edmond Eary, MD; Erwin L. Fitzgerald, MD; Salomea Goldberg, MD; Donald H. TerKeurst, MD

Macomb - Leland Brown, MD; Hyman Kurtz, MD

Marquette-Alger - Wallace G. Pearson, MD; Douglas Sherk, MD

Mason - Austin G. Craymer, MD

Monroe - G.Z. Diehl, MD; Thomas Ryan, MD

Muskegon - Antonio M. Chiasson, MD; James Stubbart, MD

North Central - Howard E. Van Oosten, MD

Northern Michigan - William Eppler, MD; John A. Sheets, MD

Oakland - Mohsen M. Avaregan, MD; Kambiz Ayrom, MD; Richard T. Browne, MD; Robert Dustin, MD; Alfredo Ferreyra, MD; Michael Grishkosh, MD; Stuart Hamburger, MD; James Huebner, MD; Robert Karalian, MD; Linda Kole, MD; Robert T. Lyons, MD; Richard E. Noon, MD; Jarlath Quinn, MD; John H. Romanik, MD; Robert Selman, MD; John H. Stunz, MD; Yoeh M. Ting, MD; Edwin J. Westfall, MD; Thaddeus Zwirkoski, MD

Ottawa - Peter A. McArthur, MD; Margaret D. Van Wylen, MD

St. Clair - Glenn F. Thomsu, MD

St. Joseph - Donald R. Schimnoski, MD

Washtenaw - Robert A. Buchanan, MD; Richard Dillman, MD; Irving Feller, MD; Winslow Fox, MD; Courtland Schmidt, MD

Wayne - Eduardo Archiniegas, MD; Maxwell Bardenstein, MD; Eugene Brooks, MD; Raymond Buck, MD; Richard G. Butler, MD; Moises G. Coto, MD; James G. Edwards, MD; Jerome Finch, MD; F.N. Ferrer, MD; Thomas Ganos, MD; Salvador Gonzales, MD; Robert L. Hanquist, MD; Tai H. Kim, MD; William C. Larsen, MD; Louis F. Lawrence, MD; David I. Levy, MD; Carl E. Lipnik, MD; Roger F. McNeil, MD; John M. Malone, MD; George Reno, MD; Andrew Stefani, MD; L.C. Sultzman, MD; Robert Toleff, MD.

■ REPORT OF BOARD ACTIVITIES ■

Jack L. Barry, MD, Chairman



Eight MSMS past presidents gathered for a photo the evening of the presidential ball. They are (l to r): Thomas R. Berglund, MD; Carl A. Gagliardi, MD; Brooker L. Masters, MD; Robert D. Burton, MD; Robert E. Paxton, MD; Brock E. Brush, MD; Richard J. McMurray, MD; Louis R. Zako, MD.

The Board of Directors is responsible for carrying out the dictated policies of the House of Delegates and to act for the Society as a whole and for the House of Delegates between sessions of the House. The 34 members of your Board, including officers, have labored throughout the year to fulfill this responsibility.

Informational Items

The Board is bringing to the 1992 House of Delegates 18 Action Reports. Fourteen of those reports deal with resolutions referred to the Board for study by the 1991 House of Delegates. Each of these reports has been referred by the Speaker of the House of Delegates to a specific reference committee for consideration by the House.

Following the request of the 1990 House of Delegates, the Board of Directors adopted a new Strategic Plan. The development of this plan was a very intense process, culminating with what the Board believes is an excellent plan to direct the Society's activities and resources. Forward-looking organizations, and we believe MSMS is one of them, review their plans every two to three years to be sure that they are consistent with the established objectives or have the flexibility to change to the objectives their membership wants them to pursue. We coupled our strategic planning process with an all-member survey and have come up with very strong compatibility between our memberships wants and needs and the direction of the Medical Society.

MSMS is proud of the strides we have made toward attaining the goals set forth in the 1991 Priorities. This could not have been done without the dedicated services of our task forces, committees and support staff.

MEDICAL LIABILITY REFORM

Last year's priority goal of developing a coalition made up of MSMS, the Michigan Hospital Association, the Michigan Association of Osteopathic Physicians and Surgeons, along with representatives of business, insurers, seniors, consumers and

others has been highly successful. Currently nearly 60 organizations make up the Michigan Medical Liability Reform Coalition.

MSMS and the Coalition are fighting for legislation based on California's highly successful and constitutionally-upheld Medical Injury Compensation Reform Act (MICRA) of 1975. That legislation includes controls on "pain and suffering" awards, a tighter statute of limitations, improvements in expert witness qualifications, a sliding scale contingent fee and pre-suit notification.

The bills, SBs 248-249, already have passed the Senate and virtually identical bills have been introduced in the House of Representatives. The goal now is to have the House pass these bills, HBs 5434-5435.

MSMS also pressed for countersuit legislation and petitioned the Michigan Supreme Court to establish a sliding scale contingent fee.

MSMS supported an emergency room immunity bill, proposals for a public fund to cover certain categories of impaired newborns and the establishment of a legal defense fund and indemnity for physicians treating Medicaid patients.

REPRESENTING PHYSICIANS IN THE LEGISLATURE

MSMS provided testimony in support of physician licensure and discipline reform legislation. We also testified in support of many anti-tobacco bills.

MSMS continues to vigorously oppose various efforts to expand the scope of practice for allied health groups including chiropractors, optometrists and nurse practitioners.

MSMS successfully opposed the imposition of the workers' compensation fee schedule for no-fault auto insurance claims. MSMS, through its specialty society representatives, also worked on successful revisions to the workers' compensation rules and fee schedule.

MSMS worked to increase Medicaid physician reimburse-

Continued on following page

Continued from page 37

ment by 15 percent, and we were successful in passing legislation to exempt certain anabolic steroids from the triplicate prescription requirements.

MSMS continues to oppose mandatory HIV testing of health care workers and opposes mandatory reporting of HIV-infected health care workers.

MSMS continues to support legislation to require primary enforcement of the mandatory seatbelt law.

MSMS initiated legislation to develop a standardized medical billing claim form, and we continue to work to implement a Medicaid drug utilization review program.

Physicians also testified on the issues of health care access and cost containment.

PATIENT ADVOCACY AND QUALITY OF CARE

During the past year MSMS voiced its concerns about the serious problems of the Medicaid population through its Medicaid Liaison Committee with the Michigan Department of Public Health. The Committee was active in the implementation of the Medicaid resource-based relative value scale which resulted in a 15 percent increase in physician reimbursement. The Committee also was active in the expansion of the Physician Sponsor Plan and in developing "Michigan Principles of Drug Utilization Review."

Patient advocacy also was the driving force for activities in the Liaison Committee with the Michigan Department of Public Health. MSMS has been active through that committee in seeking a doubling of the cigarette tax and taxing other tobacco products in an effort to reduce use of those products. The committee was most active in the development of the report, "Michigan Recommendations on HIV-Infected Health Care Workers" that opposes mandatory testing of physicians and other health care workers. The MSMS Board has endorsed these recommendations (see Action Items).

MSMS continued its contract with the Michigan Department of Public Health to investigate and review all maternal deaths in Michigan, information that is then turned over to the MDPH.

MSMS took the lead on the highly-debated issue of physician-assisted suicide. The MSMS Bioethics Committee has hosted three forums to discuss the issue with ethicists, legislators, religious leaders and representatives from Hospice, Hemlock Society, Right to Life, and senior groups. More forums are planned. The goal is to develop a societal consensus on the issue. In October, the Board adopted the recommendations of the American Medical Association on physician-assisted suicide until the 1992 House of Delegates had an opportunity to review them. These recommendations have been forwarded to the House for consideration via Board Action Report #15.

MSMS continued to educate patients about the new "patient advocate" law which enables patients to appoint others to make life and death decisions in the event the patient is incapacitated. MSMS has distributed nearly 500,000 Durable Power of Attorney for Health Care forms to physicians, hospitals and attorneys across Michigan.

MSMS continued to work with specialty societies to encourage the development of practice parameters and expanded risk management programs to county societies, specialty societies and Michigan medical schools.

A highly successful series of practice management seminars and risk management seminars for physicians and office staffs were offered last year, with 3,529 attendees. Nearly 60 practice management seminars will be made available again this year.

CHEMICAL DEPENDENCY

In 1990, MSMS, the Wayne County Medical Society and the Detroit Medical Society joined the State Bar of Michigan in a very successful effort to provide drug education programs in all of Detroit's elementary schools. A similar program was held in conjunction with the Oakland County Medical Society. During 1991, a formal curriculum was developed and now the programs have been offered to schools statewide. To date, 75 school systems have asked for the program.

MSMS continued to work, through the Impaired Physicians Program, for the rehabilitation of physicians caught in the trap of chemical dependency, in an effort to return them to productive practices.

PHYSICIAN IDENTITY/MEDIA/ PUBLIC RELATIONS

Requests for information and interviews soared last year as health care has become a major topic of interest to the public and the media. MSMS leadership handled a record number of interviews during the past year.

MSMS held an additional four county society-based media training workshops for physician spokespeople which led to the expansion of the Physicians Communication Network to approximately 200 members who provide physician viewpoints on breaking news to local media outlets.

ACCESS FOR THE UNINSURED

MSMS continued to promote the American Medical Association's 16-point plan to improve access for the uninsured called "Health Access America." The plan calls for uniform Medicaid programs in all states and a mandatory minimum benefits package for all working people, with tax incentives and risk pools offered to employers. MSMS assisted with several media tours to outlets in Michigan by AMA leadership, including AMA President John Ring, MD.

MSMS discussed various national health care reform proposals with business and labor leaders, state legislators and health planners, pointing out the strengths of the current system and showing that national health insurance is not the answer.

REPRESENTING PHYSICIANS ON THE ECONOMICS OF MEDICAL PRACTICE

During the past year MSMS fought hard through the Physician Contract Advisory Committee and through state legislators to improve a variety of issues involving Blue Cross/Blue Shield of Michigan including medical necessity determination, prior authorization, exceptions to the appeals process and the reimbursement differential between Michigan and surrounding states. The Blues and MSMS have agreed to investigate the reimbursement differential through an independent researcher.

MSMS mobilized physicians to write and visit US representatives and senators to improve the conversion factor in the RBRVS and to fight other onerous elements of the RBRVS.

Results were mixed, with vast improvements in some areas and little in others. MSMS and the AMA will continue to press for improvements in several areas including EKG interpretations and payment reductions to new physicians. MSMS also fought additional physician "hassle" legislation in mandated programs.

MSMS continued to offer the services of its Reimbursement Ombudsman for physicians and patients dealing with difficult Medicare and Blue Cross/Blue Shield problems.

REPRESENTING PHYSICIANS IN LEGAL MATTERS

MSMS supported physicians in legal matters through amicus curiae briefs. This year the Michigan Supreme Court rendered a significant decision in favor of physicians in *Domako v Rowe* consistent with an MSMS amicus brief. The decision allows unilateral defense interviews with the plaintiff's treating physician when the physician-patient privilege has been waived by the plaintiff by lack of timely assertion.

REPRESENTING PHYSICIANS WITH HOSPITALS AND MPRO

MSMS collected and disseminated information on a variety of issues through the Hospital Medical Staff Section, including advice on maintaining contemporary medical staff by-laws and advice regarding hospital medical staff-board-administration dispute resolution.

MSMS continued its role as an advocate for the physician with MPRO, peer review, quality assurance and utilization review. MSMS developed and distributed a detailed physician guide to addressing an MPRO inquiry or denial aimed at a successful reconsideration by MPRO reviewers. Tutorial sessions were held around the state.

MSMS continued to work with county medical societies and senior organizations to establish Medicare voluntary assignment programs.

The challenges of rural medical practice and rural health care delivery continued to be addressed.

COMMUNICATION WITH THE PROFESSION

Editorial content of both *Michigan Medicine* and *Medigram* now are based on the MSMS Strategic Plan to ensure that they are devoted to topics of importance to members. New features in the journal spotlight members' opinions, news about county societies, members' reimbursement questions and MSMS actions. The journal, once again, won a prize in the Sandoz Medical Journalism Awards competition.

Continued effort by the publications staff to cut the Journal's costs without cutting quality resulted in a savings of approximately \$35,000 in FY 1990-91. The MSMS subsidiary, Abbott Press, began printing *Medigram* in November. Both the journal and the newsletter enjoyed high readership marks in the 1991 MSMS membership survey.

MSMS produced a new reference book, the "Physicians Guide to Michigan Law and Medical Practice Resources." The MSMS Committee on Communications and Professional Relations also initiated a community service awards program, asking county societies to name one member each for recognition. Names of physicians chosen were announced to statewide media just prior to Doctors' Day on March 30 and were to be

recognized at the MSMS House of Delegates meeting.

MEMBERSHIP RETENTION, RECRUITMENT AND UNITY

MSMS membership increased slightly this year to 11,903. Of that total, 8,817 are active regular members, 596 are students, 835 are life members, and 1,276 are retired physicians. AMA membership slipped this year resulting in the reduction of the AMA delegation from 12 delegates to 11. With the assistance of AMA, MSMS has undertaken an intensive effort to recruit and retain AMA members this year.

AIDS EDUCATION

MSMS continued to lead the state in AIDS education through a renewed contract with the Michigan Department of Public Health for the AIDS Provider Education Program. This program has provided nearly 50,000 people, including physicians and other health care workers, with the most current information on AIDS prevention, diagnosis and treatment.

FY 1992-FY 1993 THREE-YEAR FISCAL PLAN

The Operating Fund ended FY 1991 with a net surplus of \$554,284. This exceeded the \$332,379 surplus projected in the FY 1991-FY 1993 three-year fiscal plan approved by the House of Delegates in 1990. The Finance Committee and the Board achieved the additional \$221,905 surplus by increasing non-dues revenues, reducing expenses and reallocating overhead costs to lower taxes on non-dues income. Additionally, revisions are now being made to the FY 1992 Operating Budget and we anticipate a \$370,000 surplus. These two surpluses will be incorporated in the planning to offset anticipated deficits in FY 1993 through FY 1995.

NON-DUES INCOME

MSMS continued to seek ways to increase non-dues income including the development this year of a printing company designed to capture the expenses and control the quality of MSMS printing needs including *Medigram*, seminar promotional materials, MSMS stationery, durable power of attorney for health care forms, and other items. The printing company, called Abbott Press, also is soliciting outside printing jobs. It operates under the umbrella of the Physician Holding Company, which also includes our other for-profit subsidiaries, Physician Service Group, Inc., and the Physician Review Organization of Michigan.

The MSMS practice management seminars and risk management seminars, designed to improve office operations as well as to promote the ease of delivering quality health care, continued to offered and will remain available to meet current demand of physicians and office staff. Practice management topics include setting up a practice, investments, retirement planning, coding, medical records and collections and billing.

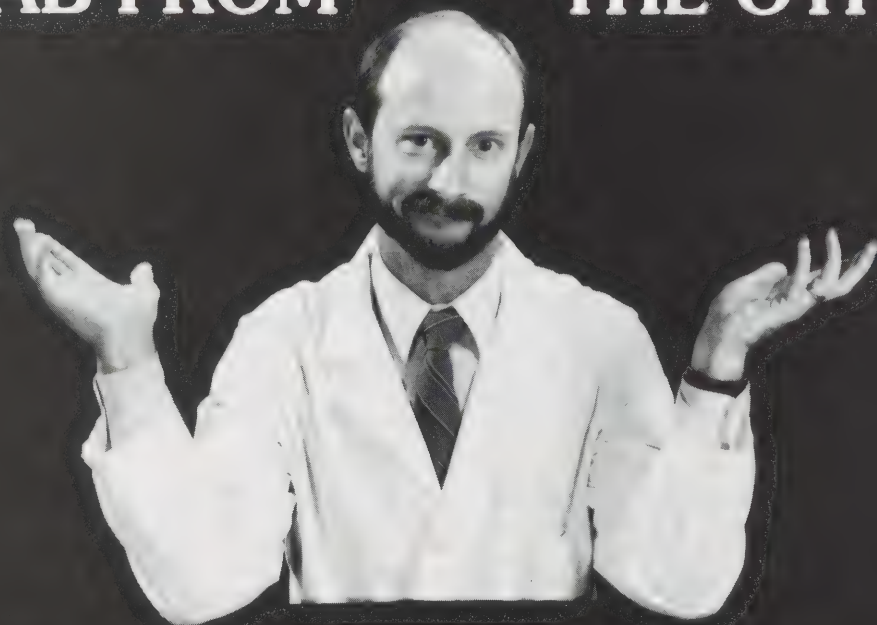
MSMS subsidiaries and educational seminars now generate more than 40 percent of MSMS revenues.

MSMS TAX CASE

As a result of the IRS audit of MSMS for FY 1986 and FY 1987, the IRS asserted two separate claims. The first claim involved a

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penalty tax of approximately \$250,000 for allegedly commingling MDPAC funds with MSMS funds. MSMS contested the claim through MSMS Legal Counsel and ultimately prevailed in full on this technical claim.

The second claim involved a rejection by the IRS of deductions for *Michigan Medicine* losses against unrelated business income. The IRS asserts that *Michigan Medicine* was not published with a profit motive and, therefore, losses could not be deducted from taxable income. This claim also approximates \$250,000, and is ongoing. The IRS has been adamant not to settle based upon a similar case decided against the West Virginia State Medical Society.

The MSMS Board directed Legal Counsel to litigate this claim in Federal District Court which requires, as a condition precedent, the payment of the taxes. MSMS filed amended tax returns claiming refunds and paid the taxes. Surprisingly, the IRS returned the payments in full, plus interest. Since the IRS has continued to demand payment of the taxes, it is anticipated that it will claim the refund was paid by mistake. Although no litigation has been commenced, legal counsel will vigorously oppose repaying the taxes that were refunded on the basis that the refund was pursuant to proper authority and the position consistently asserted by MSMS.

POLICY ACTIONS OF THE BOARD

Since the last meeting of the House of Delegates, the Board has considered some matters where MSMS policy was not clear or did not exist. In these instances, the Board has taken action which constitutes statements of MSMS policy. These statements are given below for the information of the Delegates. They will be incorporated in the MSMS Policy Manual along with the policy actions of the 1992 House of Delegates.

1. *Statement on Informed Consent*. (Adopted at September 11, 1991, MSMS Board of Directors Meeting.)

"The Michigan State Medical Society strongly endorses the principle of informed consent for medical treatment. Patients have a right to participate in decisions regarding their health care to the extent that they wish; and they have a right to the information necessary for meaningful participation.

"However, a right to the information necessary to participate to the extent that the patient desires does not imply that patients should be forced to accept information deemed relevant by an outside party. Respect for patient's rights entails respecting a patient's desires to receive or not to receive particular items of information.

"In order to respect patients' rights in a compassionate manner, information disclosure should be tailored to the particular needs and desires of the individual patient. The Michigan State Medical Society opposes regulatory interference in the physician-patient relationship, either to prohibit the physician from discussing certain information, or requiring that certain information be disclosed in all cases regardless of patient circumstances.

"The Michigan State Medical Society also believes that current law requires informed consent for all medical treatment and offers adequate recourse if consent is not obtained. Therefore, the Society sees no need for specific legislation

mandating informed consent for particular procedures or diseases."

2. *HIV-Infected Health Care Workers*. At its October 30, 1991, meeting the MSMS Board of Directors supported the Michigan Recommendations on HIV-Infected Health Care Workers prepared by the Ad Hoc Committee on HIV-Infected Health Care Workers.

Action Items

Action Report #1: Resolution #1-91A - Bicycle Helmets

RECOMMENDATION: That the House of Delegates adopt Resolution #1-91A which asks MSMS to seek legislation requiring cyclists to wear approved helmets at all times.

The Board referred this issue to the Committee on State Legislation and Regulations. The Committee was informed that House Bill 4842 was introduced by Representative David Gubow (D-Huntington Woods) which would address the issue of child cyclists. HB 4842 would require that all children under the age of four riding on a bicycle or as a passenger on a carrier attached to a bicycle, must wear properly fastened crash helmets.

According to the National Safe Kids Campaign in 1989, more than 800 bicyclists (of all ages) were killed. Almost half of all bike deaths involved children 14 and under. An estimated 580,119 bicyclists (of all ages) were treated in emergency rooms for bike-related injuries in 1990. More children are killed on cycles than on skate boards, roller skates, big wheels and scooters combined. Statistics indicate that bicycle helmets reduce the risk of head injury by 85 percent and the risk of brain injury by almost 90 percent. The National Safe Kids Campaign has estimated the annual cost of bike-related injuries and deaths at \$7.6 billion.

The Board supports this recommendation.

Reference Committee E on Public Health and Miscellaneous recommended Board Action Report #1 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #2: Resolution #13-91A - Young Physicians Section (YPS) Delegate Funding

RECOMMENDATION: That the House of Delegates adopt this report in lieu of Resolution 13-91A.

Resolution 13-91A requested that MSMS fund all delegates and alternates to the AMA-Young Physicians Section Interim and Annual Assembly meetings.

In the past, MSMS provided funds for two representatives of the MSMS-YPS to attend these meetings. However, due to a reorganization of the AMA-YPS, Michigan was awarded an additional delegate and alternate to the Assembly meetings. The reorganization was from a one delegate/one alternate per state model to a proportional model, with delegates/alternates based on the actual number of AMA young physicians per state. Michigan was one of 14 states whose delegation size was increased because of this move.

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MSMS has been extremely supportive of young physician members and believes that providing the funding for these physicians to participate in the two-day YPS Interim and Annual Assembly meetings will only enhance the continuation of organized medicine in the future. Young physicians are the leaders of tomorrow and MSMS is pleased to have these members seek further activity at the national level. Monies for these physicians were included with the 1992 budget and was based on the funds allocated for the Michigan Delegation to the AMA.

The Board supports this recommendation.

Reference Committee on Ways and Means recommended Board Action Report #2 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #3: Resolution #29-91A - Post Operative Care

RECOMMENDATION: That this report be adopted in lieu of Resolution #29-91A.

House of Delegates Resolution 29-91A was referred to the Board of Directors for further study and asked that MSMS support the position that post-operative care must be provided by the operating surgeon or an equivalently trained and licensed physician.

The Board referred this resolution to the Committee on Medical Licensure and Discipline. The Committee believes that in some cases, it may not be possible for the operating surgeon to provide the post-operative care. However, the Committee believes that if the operating surgeon is unable to provide the post-operative care, that the individual who replaces him or her be supervised by the operative surgeon.

The Board supports this recommendation.

Action Report #4: Resolution 32-91A - Support for the Appeal of the Determination Report on the BCBSM Medical Doctors Provider Class Plan

RECOMMENDATION: That the House of delegates adopt this report in lieu of Resolution 32-91A.

Resolution 32-91A asks for MSMS to give financial support to the appeal of the Insurance Commissioner's Determination Report on the BCBSM Medical Doctors Provider Class Plan for 1987-88. The resolution was referred to the Board for study.

MSMS is currently using several avenues to generate improvements—some involving legislation, others involving interaction with BCBSM Board members and staff. These activities and the activities of physicians pursuing legal action against BCBSM have complemented each other. The appeal has certainly generated pressure that is useful in creating an environment for change. MSMS has provided information to the attorneys involved in the appeal, and our positions and actions were helpful in establishing a basis for many of their arguments.

The Board of Directors hopes this productive exchange can continue, but believes direct financial support of the appeal by MSMS would hamper our effectiveness in the forums we are using to pursue change.

Background on the Appeal

The appeal related to the Provider Class Plan was initiated by attorneys Gilbert Frimet and Andrew Wachler on behalf of two separate groups of petitioners, including several physicians. At the time of the 1991 House of Delegates meeting, the appeal was within the jurisdiction of the Michigan Insurance Bureau.

Hearings before the Bureau's Independent Hearing Officer, Judge Robert L. Borsos, lasted nearly ten months; a decision was issued in August, 1991.

The decision reversed the findings of former Insurance Commissioner Dhiraj Shah that BCBSM had met the goals of P.A. 350 or that their failure to do so was reasonable. Judge Borsos' decision called for BCBSM to submit a new Provider Class Plan for his review by February 1992. Judge Borsos ordered BCBSM to pay the petitioners' costs for bringing the appeal. The decision was appealed by BCBSM and in November, 1991, the Michigan Court of Appeals granted BCBSM leave to appeal and stayed all orders pursuant to Judge Borsos' August decision. The Michigan Court of Appeals action came after attempts by Insurance Commissioner David Dykhouse to wrest jurisdiction over the matter from Judge Borsos and a separate order by Dykhouse to have BCBSM develop a new Provider Class Plan pursuant to the decision.

In an order issued subsequent to his August 5, 1991, decision, Judge Borsos ordered BCBSM to pay petitioners' attorney fees and costs in an amount over \$700,000. Both the order involving costs and the matter of who has future jurisdiction—Judge Borsos or the Insurance Commissioner—will now be decided by the Michigan Court of Appeals.

MSMS Activities

MSMS has pursued a multi-faceted approach to initiating changes in the BCBSM physicians' contract and in BCBSM service to physicians. This approach includes discussions with BCBSM Board members through the Physician Contract Advisory Committee (PCAC), legislative and administrative advocacy, cooperative efforts with physicians and attorneys involved in the appeal to develop recommendations about a BCBSM Provider Class Plan and Liaison Committee discussions with BCBSM staff.

The BCBSM Physician Contract Advisory Committee was created by the BCBSM Physicians and Professional Providers Participating Agreement to provide a forum for discussion of concerns about the contract. The Committee includes eight members of the BCBSM Board of Directors and eight physicians—five from MSMS and three from MAOP&S.

Since its inception in September, 1990, the PCAC has been successful in generating revisions to the contract involving the definition of medical necessity, payment of interest on delayed claims, and a cap on physician cost for appeals.

As a result of PCAC discussions, a payment increase for 1992 will be recommended to the BCBSM Board of Directors. The PCAC is engaged in an ongoing effort to expedite BCBSM approval of coverage for new procedures, with over 100 new procedures approved so far.

In 1992, the PCAC will review the departicipation criteria in the contract and problems related to appeals of departicipation decisions. The PCAC will also pursue further study of differences between payment and use of health services in Michigan and in

surrounding states, to determine what factors might contribute to those differences.

Advocacy with the Legislature and Insurance Commissioner has also been important in MSMS efforts. Last fall, MSMS leaders met with Insurance Commissioner David Dykhouse to discuss concerns about the BCBSM Provider Class Plan and to urge him to pursue development of a new plan. Although intervention from the Insurance Commissioner may be precluded by the Michigan Court of Appeals action staying all orders relative to the 1987-88 plan, MSMS plans to continue to discuss physician concerns with the Commissioner.

Many legislators are also concerned about BCBSM relations with physicians and subscribers. Legislative concern about low physician participation with BCBSM in Western Michigan led to the creation of the Special BCBSM Committee. The Committee was specifically charged with identifying and implementing solutions to 44 problems cited as reasons for low physician participation. As a result of that process, SB 432 was introduced to address many physician concerns, specifically those related to appeals, utilization review, medical necessity and provider and customer service. The bill is currently pending before the Senate Health Policy Committee.

In the House of Representatives, legislators from Western Michigan have joined with legislators from the Detroit area in calling for a comprehensive examination of P.A. 350 and BCBSM operations. Many of the issues identified through the Special BCBSM Committee will be part of this effort, along with concerns related to BCBSM premiums, administrative services only business and payment to physicians. Strong legislative interest in both chambers is clearly putting pressure on the Blues to be more responsive to physician concerns.

The Board of Directors is observing many positive changes as a result of our activity, and legislative and administrative pressures. In 1991, following release of an MSMS survey showing little or no improvement in BCBSM provider inquiry services, BCBSM began providing regional provider inquiry service to physicians in the 616, 517 and 906 area codes and added staff to the provider inquiry area. This activity coincides with the opening of a regional service office in Western Michigan. At our suggestion, BCBSM has expanded the availability of its computer point of contact benefit and eligibility verification service. Late in 1991, BCBSM eliminated over 800 procedures from preadmission certification requirements.

MSMS will continue to pursue changes of this nature through direct discussions with BCBSM and through legislative advocacy. We recognize though, that the Provider Class Plan is a pivotal tool in bringing about improvements to the physician contract and to BCBSM service to physicians. Last fall, the MSMS Board of Directors appointed an eight-member Task Force on the BCBSM Provider Class Plan. Task Force membership includes physicians who have supported the appeal and representatives of the MSMS Liaison Committee with BCBSM. The Task Force is developing very specific recommendations on issues that relate to the Provider Class Plan goals of cost, quality and access. Although the Court of Appeals action may delay immediate activity on a Provider Class Plan, the Board believes it will be important for MSMS to be ready with specific recommendations about a Provider Class Plan whenever a new one is developed.

Financial Support of the Appeal

To date, the appeal has been financed through donations from private physicians, specialty societies and hospital medical staffs. Many physicians involved in the appeal are concerned about raising the funds necessary to pursue the appeal through the judicial process.

The cost of future action is uncertain, as is the time frame for a decision. If MSMS contributes directly to the appeal, we risk cutting off other avenues for change. As described above, these avenues have been successful. It is particularly important to note that the progress made in recent years has been achieved within the confines of our current dues structure and budget. Blue Cross Blue Shield reform is certainly important to our members, but we cannot ignore their other needs and priorities, including medical liability reform, implementation of the RBRVS by Medicare, Medicaid and other payers, scope of practice issues, continuing medical education and professional and public relations.

MSMS has provided non-financial support to the appeal. We have provided information to members wishing to contribute to the appeal. Through *Medigram* and *Michigan Medicine*, MSMS has provided information about the progress of the appeal and its importance to overall efforts toward reform. Attorneys involved in the appeal have spoken at several physician forums, many directly arranged by MSMS. Instead of making a financial commitment that would jeopardize our ongoing efforts toward BCBSM reform and activities in other areas, the Committee believes MSMS should continue to seek ways to support the appeal without a financial contribution.

Reference Committee A on Medical Care Delivery recommended that Board Action Report #4 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #5: Resolution #34-91A - Identify Illustrations of Defensive Medicine

RECOMMENDATION: That this report be adopted in lieu of House of Delegates Resolution #34-91A.

Resolution #34-91A asks that MSMS undertake a study of "defensive medicine" and its cost impact on total health care costs and its effect on physician behavior. Resolution #34-91A was referred to the Board of Directors for further study.

In examining this Resolution, the MSMS Task Force on Professional Liability reviewed information supplied by the American Medical Association concerning defensive medicine costs. The AMA found that in 1989, the cost of defensive medicine in the United States was \$15.1 billion. This amount represents a significant increase from the estimated defensive medicine costs of \$4.8 billion in 1982, but a reduction from the estimated costs of \$17.5 billion in 1988.

The Task Force believes it is very likely that the actual amount of defensive medicine that is practiced in the United States far exceeds \$15.1 billion, as estimated by the AMA.

The Task Force recognizes, however, that it is extremely difficult to determine in specific cases, what is defensive medicine and what is good medical practice. As a result, it is virtually impossible to accurately estimate the amount of defensive

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medicine that exists in Michigan and in the United States. Because of the difficulty in quantifying the cost of defensive medicine and the high cost of undertaking a study of defensive medicine costs, the Task Force believes that MSMS should not undertake a study of the impact of defensive medicine on total health care costs. At the same time, however, the Task Force believes that MSMS should solicit from physicians examples of defensive medicine in their practice.

The Board supports this recommendation.

Reference Committee D on Professional Liability recommended Board Action Report #5 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #6: Resolution #38-91A - Public Information Campaign to Michigan Consumers

RECOMMENDATION: That the House of Delegates adopt Resolution 38-91A.

House of Delegates Resolution 38-91A (referred to the Board of Directors for further study) asked that MSMS expand its current "43 Cents on the Dollar" campaign that addresses the impact of underfunding of the Medicaid program. The resolution also requested that MSMS physicians educate their patients about the additional negative effects of present and future budget cuts and encourage them to write letters to their legislator.

The Board referred this resolution to the Medicaid Liaison Committee. The Medicaid Liaison Committee strongly supports the intent of this resolution. The Committee believes that, despite the 15 percent increase in Medicaid reimbursement which became effective on December 1, 1991, Medicaid physician reimbursement is still grossly inadequate to ensure access to care for Medicaid beneficiaries. As a result, the Committee believes that the "43 Cents on the Dollar" campaign should be continued to highlight the fact that the Medicaid program is still woefully underfunded under the new Medicaid fee schedule. Medicaid physician reimbursement is still less than 70 percent Medicare reimbursement. The Committee is hopeful that continuation of the "43 Cents on the Dollar" campaign may lead to additional increases in Medicaid physician reimbursement.

The Board supports this recommendation.

Reference Committee C on Internal Affairs and Public Service recommended Board Action Report #6 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #7: Resolution #50-91A - Health Care Administration Cost Cap

RECOMMENDATION: That this report be adopted in lieu of Resolution #50-91A.

House of Delegates Resolution 50-91A (referred to the Board of Directors for further study) asked that MSMS seek state legislation capping administrative health care expenses at 10 percent. The resolution also asks that the AMA seek similar legislation at the federal level.

The Board referred this resolution to the Committee on State Legislation and Regulations. The Committee on State Legislation and Regulations strongly supports the intent of this resolution. The Committee believes that this resolution should be amended so that MSMS seek state legislation capping administrative expenses for all third party payors at 10 percent. The Committee also expressed concern of introducing state legislation that does not address federal mandates. Therefore, the Committee strongly suggests that MSMS first work with the AMA in developing model legislation to achieve this goal.

The Board supports this recommendation.

Reference Committee B on Legislation recommended Board Action Report #7 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #8: House of Delegates Resolution 70-91A - "Student Loan Endowment Fund"

RECOMMENDATION: That the Board recommend that this report be adopted in lieu of Resolution 70-91A.

Resolution 70-91A requests that MSMS create a student loan endowment fund. The fund would be used for the sole purpose of extending low interest loans to Michigan medical students, who are members of MSMS and attend one of Michigan's three medical schools. The students would repay the loan upon completion of their medical training, thus sustaining the fund. The resolution was referred to the Board for study. The Board referred this resolution through the Treasurer to the Health Education Foundation because the Foundation had previously operated a student loan program in the 1960s and 70s but discontinued it in the early 1980s.

The Health Education Foundation Board of Trustees considered this resolution at its September 25, 1991 meeting. The Board of Trustees determined that it would not be appropriate for the Foundation to re-establish a student loan program for the following reasons:

1. The experience of the Foundation with student loans was unsatisfactory due to difficulties in collecting loan payments and defaulted loans; and
2. MSMS Legal Counsel advised the Foundation Board of Trustees that the Foundation could not legally restrict a student loan program to medical students who are members of MSMS and attend one of Michigan's three medical schools. This restriction would also apply to any loan programs sponsored by MSMS.

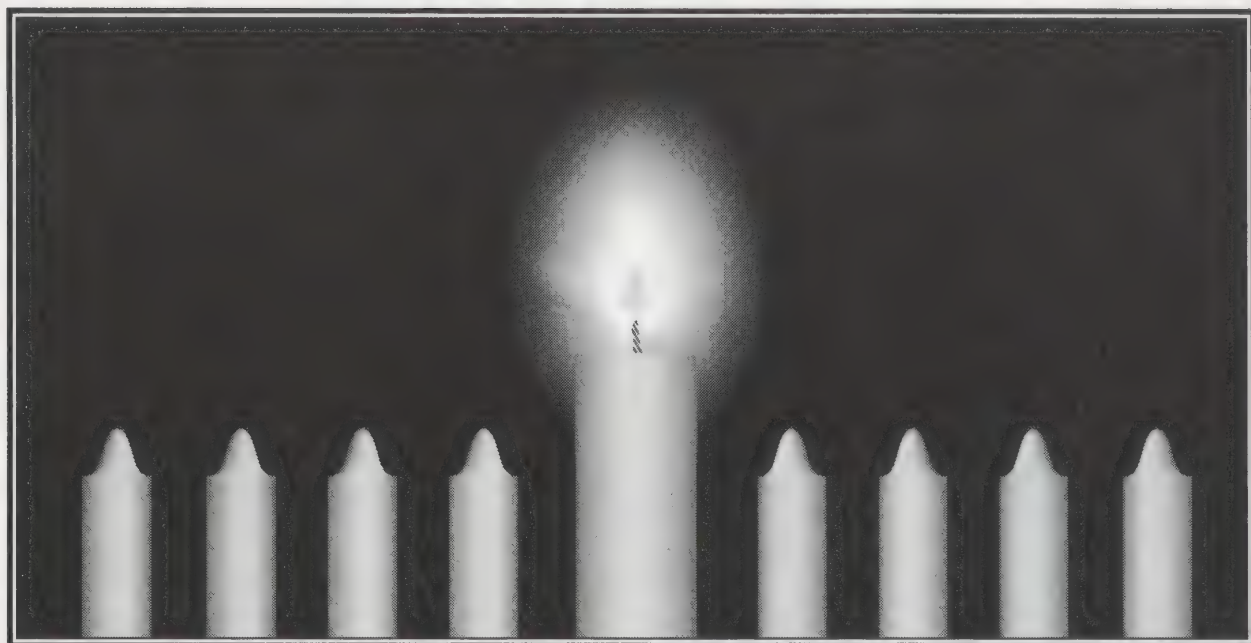
Additionally, the Foundation Board of Trustees concluded that operating a student loan program is not consistent with the mission statement of the Foundation and is beyond the current scope of the Foundation activities. The Foundation also noted that in the current economic climate it is having difficulties in attracting contributions from physicians to carry on its present activities.

Reference Committee on Ways and Means recommended Board Action Report #8 be adopted.

The House approved the recommendation of the Reference Committee.

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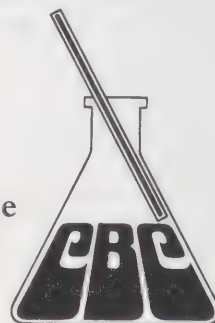
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Action Report #9: Resolution 73-91A - Develop Michigan Externship Programs for the International Medical Graduates (IMGs)

RECOMMENDATION: That this report be adopted in lieu of House of Delegates Resolution 73-91A.

Resolution 73-91A was referred to the MSMS Board and subsequently to the Executive Director for study. This resolution requested that MSMS explore ways to work with interested groups to provide externship programs for international medical graduates so that they can be accepted into training programs.

After examining the objective set forth in Resolution 73-91A, that is, assisting IMGs in obtaining residency positions, and learning that the IMG Governing Council is already working to develop and expand its recently approved "Program to Assist Non-Matched IMGs Following Match Day," and other educational programs, such as the residency seminars and accent reduction workshops—all of which constitute a more effective means of providing the training many IMGs need—it is recommended that MSMS not pursue externship program for IMGs.

The Board supports this recommendation.

Reference Committee F on Medical Education and Miscellaneous recommended Board Action Report #9 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #10: Resolution #83-91A - Uniform Licensing of Physicians

RECOMMENDATION: That this report be adopted in lieu of Resolution 83-91A.

House of Delegates Resolution 83-91A (referred to the Board of Directors for further study) asked that MSMS support legislative redress to ensure uniform licensing requirements of allopathic and osteopathic physicians in Michigan.

The Board referred this resolution to the Committee on Medical Licensure and Discipline. The Committee believes that it is inappropriate for allopathic physicians to attempt to alter the licensing requirements of osteopathic physicians.

Historically, the two-year post-graduate training requirement for allopathic physicians, came about as a compromise with the International Medical Graduates (IMG) Section. Originally, the IMG's were required to perform three years of post-graduate training while non-IMG's were only required to perform one year.

This compromise, according to the Committee, in no way should involve osteopathic physician's post-graduate training requirements.

The Board supports this recommendation.

Reference Committee D on Professional Liability recommended Board Action Report #10 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #11: Resolution 9-91A - Blue Cross Blue Shield of Michigan (BCBSM) Provider Class Plan

RECOMMENDATION: That the House of Delegates adopt this report in lieu of House of Delegates Resolution 90-91A.

Resolution 90-91A asks MSMS to request a comprehensive review of BCBSM practices by the Insurance Commissioner and Legislature and to call for development of a Provider Class Plan that address concern over differences between BCBSM payment to physicians and payment in other states. The resolution was referred to the Board for study, and subsequently referred to the Liaison Committee with BCBSM.

Through ongoing contacts with the Insurance Commissioner and interested legislators, MSMS has voiced physician concerns about BCBSM payment and other practices.

Legislation has been introduced in both the House and Senate that addresses many of our concerns. MSMS is actively supporting SB 432, which would enforce standards related to BCBSM service to physicians, significantly change the BCBSM appeals process and require BCBSM to defer to physician judgment in issues where medical necessity is in dispute. In the House, MSMS has supported provisions of legislation that would require BCBSM to improve payment to physicians by linking payment to payment in surrounding states.

Efforts in both chambers are likely to intensify this spring as the House of Representatives begins to work toward a comprehensive examination of BCBSM practices and review of the Blues' enabling act, P.A. 350 of 1980. MSMS plans active participation in this process. As part of our participation, we plan to provide information on efforts to further study differences in payment and use of health services between

Michigan and surrounding states and about how BCBSM policies conflict with the cost, quality and access goals stated in P.A. 350 of 1980.

The Insurance Commissioner has also expressed his commitment to address physician concerns through the BCBSM Provider Class Plan. Although the timing of a new Provider Class Plan is uncertain, MSMS has been working with the Commissioner to assure that physicians can have input into a new plan as it is developed. To prepare for this process, the Liaison Committee has recommended appointment of a Task Force to develop recommendations for addressing the Provider Class Plan goals of cost, quality and access.

The measures called for in Resolution 90-91A are already part of our ongoing efforts to address problems with the state's largest insurance carrier. With heightened awareness of physician concerns about BCBSM at both the Legislature and the Insurance Bureau, the Board of Directors looks forward to many opportunities to influence legislative and administrative activity in 1992.

Reference Committee A on Medical Care Delivery recommended Board Action Report #11 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #13: Resolution 103-91A - MSMS Task Force on Access to Care

RECOMMENDATION: That the Board recommend that this report be adopted in lieu of Resolution 103-91A.

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Resolution 103-91A calls for MSMS to create a Task Force on Access to Health Care. The Board of Directors recommends against creation of a separate task force on this issue. As an alternative, the MSMS Advisory Committee on Medical Economics will review and monitor state and national proposals related to access to care and make appropriate recommendations.

In 1989 and 1990, MSMS participated in then Governor Blanchard's Task Force on Access to Health Care. Despite nearly two years of exhaustive work, the Task Force was able to recommend only modest changes in state policy that would impact the availability of health care coverage. Michigan's experience mirrors that in other states, suggesting that the problems of access to care are best solved at the federal level. State legislators have developed universal access proposals for Michigan, and MSMS should certainly be active in these legislative efforts.

MSMS already is active in support of Health Access America, the AMA's plan for expanding access to health care by improving existing governmental and private insurance programs and resolving some of the flaws in the health care system that impact access to health care.

Reference Committee C on Internal Affairs and Public Service recommended Board Action Report #13 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #14: MSMS House of Delegates Resolution 104-91A, "Do Not Resuscitate (DNR) Policy"

RECOMMENDATION: That the House of Delegates adopt this report in lieu of House of Delegates Resolution 104-91A so that MSMS actions will be compatible with the Patient Advocate Act of 1990 and the current situation in Michigan.

House of Delegates Resolution 104-91A (referred to the Board of Directors for study) requested MSMS to (1) support legislation to promote universal documented discussion with patients, family and/or guardians of the DNR option, (2) encourage its members to participate actively in educating themselves and patients re DNR option, living wills, etc., seek information re best devices to alert first responders that a DNR is in place and to be honored, (4) recommend inclusion of patients' CPR wishes in hospital and extended care medical records, (5) develop guidelines to allow patients to name a guardian to decide health care issues once they become unable to do so and (6) support as much autonomy as possible for patients to decide when and how to withdraw life support, with advisors being physicians instead of the legal system.

The MSMS Board of Directors referred Resolution 104-91A to the Committee on Bioethics for review and recommendation. After a thorough review of 104-91A, consideration of the provisions of the Patient Advocate Act of 1990 and discussion of the current feasibility of hospitals, extended care facilities, other institutions and health care personnel implementing the provi-

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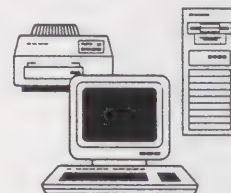
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sions of the Resolution, the Committee:

1. Believes that the Patient Advocate Act of 1990 adequately addresses all the patients' rights issues included in 104-91A.
2. Opposes specific state legislation governing "Do Not Resuscitate" (DNR) orders alone.
3. Urges MSMS to promote the spirit of 104-91A by efforts to educate all physicians on the effective implementation of the Patient Advocate Act and DNR orders.
4. Believes that 104-91A, as written, may be counter productive by its emphasis on documentation and legislation.

The Board supports the recommendation of the Committee.

The Reference Committee on Legislation recommended Board Action Report #14 be adopted.

The House approved the recommendation of the Reference Committee.

Action Report #15: Policy on Physician-Assisted Suicide

RECOMMENDATION: That the House of Delegates adopt as MSMS policy the following statements adopted by the American Medical Association at its annual meeting in June 1991.

1. The principle of patient autonomy requires that physicians must respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, thermotherapy, antibiotics and artificial nutrition and hydration.
2. There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
3. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
4. Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great in this culture to condone euthanasia or physician-assisted suicide at this time.

At its October 30, 1991, meeting the MSMS Board of Directors adopted the following motion:

"The Medical Society has grave concerns about Doctor Kevorian's actions, the general issue of physician-assisted suicide and euthanasia, and we adopt, until the next House of Delegates meeting in May 1992, the four recommendations of the AMA."

The Reference Committee B on Legislation recommended Board Action Report #15 be adopted.

The House referred Board Action Report #15 back to the Board of Directors for study.

Action Report #16: MSMS/HMSS Bylaw Amendments

RECOMMENDATION ONE: That the amendments to the MSMS/HMSS Bylaws, Resolution 12-92HMSS, as approved by the Section at its March 14, 1992, 8th Assembly, its Annual Meeting, be approved.

RECOMMENDATION TWO: That the amendments to the MSMS/HMSS Bylaws, Resolution 13-92HMSS, as approved by the Section at its March 14, 1992, 8th Assembly, its Annual Meeting, be approved.

The MSMS Hospital Medical Staff Section Governing Council reviewed the Bylaws at a February 15, 1992, meeting of the Governing Council. The Governing Council proposed the revision of the Section's Bylaws, and presented these revisions as Resolutions 12-92HMSS and 13-92HMSS to the Representatives at the 1992 Annual Meeting, Saturday,

March 14, 1992. These Bylaw amendments were "Adopted As Amended" as a matter of clarification.

The Committee on Constitution and Bylaws recommended Board Action Report #16 be adopted on first reading and laid over to the 1993 House of Delegates.

The House approved the recommendation of the Reference Committee.

Action Report #17: Amendment to IMG Section Bylaws

RECOMMENDATION: That the amendment to the Bylaws of the MSMS Section for International Medical Graduates, as approved by the Section at its 1992 annual meeting, be approved.

At its 1992 annual meeting held March 14, the MSMS Section for International Medical Graduates approved the Governing Council's action report which called for the Section to change its Bylaws so that delegates to the Section are elected through component medical societies rather than through hospital medical staffs.

The IMG Governing Council informed the delegate body that component medical society executives are far more responsive and aware of active IMGs in their counties than are hospital chiefs of staff. This is evidenced by the low response of hospital chiefs of staff in recent years.

The Bylaws of the MSMS Section for International Medical Graduates currently state:

"Each hospital having more than fifty active staff members, as determined by the hospital, may elect two delegates from its medical staff. Those hospitals with fewer than fifty active members may elect one delegate.

"The delegates shall be elected by the hospital medical staff of JCAHO accredited hospitals in Michigan. Delegates to the Annual Meeting shall be properly certified by the President, Chief of Staff or Secretary of the Medical Staff of their respective hospitals."

Continued on following page

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The Board proposes the following statement replace these two paragraphs:

Each component medical society in Michigan shall be entitled to send to the MSMS IMG Section meeting each year one delegate for each 25 voting members (active, life and retired) and one delegate for each additional major fraction thereof. Any county medical society having less than 25 members shall be entitled to send one delegate. The delegates shall be properly certified by the executive director of their respective county medical society.

MSMS Legal Counsel has indicated that these changes are appropriate and consistent with the MSMS Bylaws.

The Board supports this recommendation.

The Reference Committee on Constitution and Bylaws recommended Board Action Report #17 be adopted on first reading and laid over to the 1993 House of Delegates.

The House approved the recommendation of the Reference Committee.

Action Report #18: MSMS-YPS Bylaws

RECOMMENDATION ONE: That the revised MSMS-YPS Bylaws as adopted by the MSMS-YPS at the 1992 Annual Meeting be approved.

RECOMMENDATION TWO: That Section 20.60, of the MSMS Bylaws be amended to: "At its annual meeting the Section shall elect officers in accordance with the Bylaws of the MSMS Young Physicians Section."

After careful consideration and review the MSMS-YPS Governing Council revised the bylaws of the Section and then presented these revisions at its 1992 Annual Meeting, Saturday, March 14, 1992. The bylaws were adopted as amended at the annual meeting. The Governing Council believed the Bylaws should be updated to reflect the current activities of the Section. The Governing Council also believed the revisions were needed to provide clear and concise direction for the Section, as well as outline the duties and responsibilities for the officers of the Section.

Coupled with the recommendation for adoption of the revised YPS Bylaws, it was recommended and adopted by the Section that Section 20.60 of the MSMS Bylaws which reads: "At its annual meeting the Section shall elect a Chairman, Vice-Chairman, Secretary, Delegate and Alternate Delegate to the House of Delegates, each of whom shall serve for a term of one year" be revised to read: "At its annual meeting the Section shall elect officers in accordance with the Bylaws of the MSMS Young Physicians Section." This would simply be a housekeeping measure.

Legal counsel has reviewed these changes and finds them to be consistent with the MSMS Bylaws.

The Board supports these recommendations.

The Reference Committee on Constitution and Bylaws recommended Board Action Report #18 be adopted on first reading and laid over to the 1993 House of Delegates.

The House approved the recommendation of the Reference Committee.

Action Report #19 - Recognition of Two Specialty Societies

RECOMMENDATION: That the 1992 MSMS House of Del-

egates approve upon First Reading MSMS Bylaws amendments to recognize the Michigan Association of Medical Examiners and the Michigan Association of Public Health Physicians for specialty society representation in the MSMS House of Delegates.

MSMS received a request from Lawrence S. Loesel, MD, president, Michigan Association of Medical Examiners (MAME), for specialty society recognition by the MSMS House of Delegates. In addition, letters were received from Donald W. Lawrenchuk, MD, president, Michigan Association of Public Health Physicians, and Gordon R. Rady, MD, president, Michigan Health Officers Association, asking that the Michigan Association of Public Health Physicians (MAPHP) be recognized as the official public health physician specialty organization, replacing the Michigan Health Officers Association. It was determined that both MAME and MAPHP meet the requirements as delineated in Section 20.20 of the MSMS Bylaws:

"Other specialty organizations that wish to be included in the list of recognized specialty organizations in this chapter must meet the following criteria: a) Be a statewide specialty organization at least five years old; b) have 25 or more active physician members of whom 70 percent or more maintain their membership in MSMS; and c) be approved by the House of Delegates action, with the appropriate Bylaws amendments.

"A society must be statewide in scope, with a minimum of one meeting per year. In addition, the governing body of the society must have taken formal action requesting delegate representation; i.e., sending a letter to the MSMS Board of Directors."

The Reference Committee on Constitution and Bylaws recommended Board Action Report #19 be adopted on first reading and laid over to the 1993 House of Delegates.

The House approved the recommendation of the Reference Committee.

Action Report #20: Resolution 18-91A - Elimination of Heavy Metals and Benzene

RECOMMENDATION ONE: That the House of Delegates adopt this report in lieu of House of Delegates Resolution 18-91A.

RECOMMENDATION TWO: That MSMS ask the Michigan Delegation to the AMA to urge the AMA to work at the federal level for the elimination of lead, mercury and benzene from common household and workplace products.

Resolution 18-91A asks that MSMS seek the elimination of lead, mercury and benzene in the production of paint and other materials. The resolution was referred to the Board for study and subsequently referred to the Task Force on Environment and Health.

The Task Force has long been concerned with the presence of lead, mercury, benzene and other hazardous materials that may be used in the production of common household and workplace products. Task Force members are aware that, although use of these hazardous materials in production of paint and other household products has been curtailed in recent years, many people are still exposed to the hazards that they represent.

It would certainly be the goal of the Task Force to have all hazardous materials eliminated from use in any manufacturing

process. Efforts could be made to preclude use of hazardous materials in Michigan, but this would not address the problems of products from other states. Federal standards are needed to assure that all products are free of lead, mercury and benzene.

The Task Force plans to review existing standards and, where appropriate, make recommendation for their revisions. It is likely that efforts toward any revisions will need to occur at the federal level. In the meantime, the Task Force is equally concerned about educating consumers about potential hazards in the manufacture of household products. In 1991, the Task Force sponsored a course at the MSMS Annual Scientific Meeting that included information about lead and mercury. The Task Force will expand upon those efforts to provide physicians with information they can share with patients. This information might include a list of hazardous substances that might be found in newly-purchased products or that might already be in homes without the knowledge of the purchaser; possible alternatives for the products; and precautions for patients.

Reference Committee E on Public Health and Miscellaneous recommended Board Action Report #20 be adopted as amended.

The House approved the recommendation of the Reference Committee.

Action Report #21: Resolution 58-91A — Reconsider Joining AMA National Credentials Verification Service

RECOMMENDATION: That the House of Delegates adopt this report in lieu of House of Delegates Resolution 58-91A.

Resolution 58-91A asks MSMS to join the National Credentials Verification Service as a test state at the earliest possible time. This Resolution was referred to the Board for study, and subsequently to the Task Force on Centralized Credentialing Verification Program.

The Michigan State Medical Society (MSMS); the Michigan Hospital Association (MHA) and the Michigan Association of Osteopathic Physicians and Surgeons (MAOP&S) are cooperating in a Task Force study to determine the feasibility of establishing an independent facility to provide Michigan hospitals and physicians a centralized physicians' credentials verification service.

The membership of the Task Force is comprised of eight physicians (six from MSMS, two from MAOP&S) and eight representatives from the membership of MHA. Two members of the Michigan Association of Medical Staff Coordinators (MAMSC) serve on the Task Force in an advisory capacity.

Prior to the first Task Force meeting, a survey was conducted to determine the interest of hospitals and physicians in using a centralized service. The survey document was sent to the CEOs of 184 Michigan hospitals and to a random sampling of physicians, including physicians identified as chiefs of medical staffs. The response to the survey questionnaire was high and the results indicated a significant level of acceptance of the concept. Respondents named accuracy, confidentiality, timeliness and adherence to characteristics of credentials verification.


Following is a summary of the major decisions made by the Task Force at the three meetings held to date:

Continued on following page


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o The Task Force adopted a requirement that credentialing information received, processed and retained by the centralized facility must be protected by Michigan statute for confidentiality and freedom from disclosure. In keeping with this objective, the Task Force initiated the introduction in the Michigan Legislature of House Bill 5408. If adopted, this legislative proposal would amend PA 270 (Release of Medical Information to Review Entities) by defining a centralized facility established by "a state association of hospitals or physicians" as a peer review entity. The proposed legislation would insure the confidentiality of information received by hospitals in response to queries made to the National Practitioners Data Bank.

- A proposal to develop a uniform medical staff application to be used by future clients of the centralized facility was considered and the Task Force felt this would be inappropriate at this time.
- A report delineating purported causes of the failure of a recent Maryland centralized facility was discussed at some length by the members. By consensus it was agreed that the concept of a centralized Michigan facility remained valid and that the Maryland experience, while unfortunate, could prove to be instructive to the Task Force. The Task Force assessment of the Maryland experience focused on three critical issues which contributed to the decision to close the Maryland facility — the failure to conduct an extensive pilot project before initiating full service; little or no involvement of medical staff coordinators in planning and design of the centralized service; and, inadequate

orientation of physicians to the concept of centralized services.

The MSMS Board of Directors received and approved a report from the Task Force recommending the formation of a corporation to provide a centralized credential verification program in Michigan. The Board also approved up to \$50,000 for the purchase of stock in and/or a loan to a new credentialing entity providing the Task Force on Centralized Credentialing Verification Program submits a pro forma that is approved by the Finance Committee and the Board.

The corporation will begin this process by establishing two or three demonstration sites in cooperation with hospitals in confined geographic areas, on a limited scale, in order to gain experience over time. By beginning with limited demonstration projects, the Task Force hopes to avoid some of the problems experienced in other states, as well as to develop its internal structure and establish the administrative mechanisms necessary to expand this program statewide. Several groups of hospitals within Michigan have already expressed an interest in cooperating with this program.

The corporation will have a board of equal number of members from hospital administrators and physicians, with one of the physicians appointed by MAOP&S.

The Reference Committee F on Medical Education and Miscellaneous considered Resolutions 6-92A, 37-92A, 56-92A and Board Action Report together and recommended adoption of Substitute Resolution 6-92A.

The House approved the recommendation of the Reference Committee.

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■ SPEAKERS' REPORT ■

Robert D. Allaben, MD
Gary D. Maynard, MD

Here is a brief review of the progress in implementing the resolutions adopted at the 1991 Annual Session of the House of Delegates.

Resolutions

1-91A

Title: Bicycle Helmets. Referred to the Board for Study.

This resolution asked that MSMS and county medical societies urge the state legislature and County Boards of Commissioners to enact bicycle helmet legislation or ordinances requiring cyclists to wear approved helmets at all times.

In October 1991, Representative David Gubow introduced legislation (House Bill 5953) that would mandate the use of helmets by all bicycle riders under the age of four.

MSMS aggressively supported the passage of this legislation. It was passed by the full House in December and is currently before the Senate Committee on Transportation and Tourism.

2-91A

Title: Audio/Visual Telecommunication System. Adopted as Amended.

This resolution called on MSMS to explore modalities to increase two-way communication with Upper Peninsula physicians so they may become more involved in MSMS activities.

A model audio/visual systems developed and used for a time by the Michigan Hospital Association proved to be cost-prohibitive, so MSMS has been exploring two audio systems now in use by the Michigan Department of Public Health. These systems link parties through conference call networks, and are far less expensive than the \$352,000 MHA system which also requires an hourly \$500 transmission rate. On completion of the renovations to the MSMS headquarters, MSMS installed speaker phones in every conference room for use in making conference calls. The telephones are now in use and proving to be a valuable asset to communication around the state.

3-91A

Title: Benzodiazepine Education. Adopted as Amended.

This resolution asked that MSMS undertake educational measures for physicians about the true addictive nature of benzodiazepine.

An article on the true addictive nature of benzodiazepine has been added to the 1992 *Michigan Medicine* editorial calendar. The article is scheduled to appear in the September issue.



Robert D. Allaben, MD, speaker

The second Resolved of this resolution called on the Michigan Delegation to the AMA to ask the AMA to undertake educational measures for physicians about "the true addictive nature of benzodiazepines."

The Michigan Delegation sponsored a resolution to the 1991 Interim Meeting of the AMA House of Delegates. The AMA delegates referred the resolution to the AMA Board of Trustees.

The third Resolved of this resolution asked that one of the plenary sessions at a future MSMS scientific session be devoted to Benzodiazepine education.

A plenary session at the 1991 Annual Scientific Meeting, entitled "Drug Abuse and the Physician's Role," addressed drug abuse in general.

4-91A

Title: Benzodiazepine to Schedule II. Disapproved.

5-91A

Title: Impact of State Budget Reductions. Disapproved.

6-91A

Title: Child Care Availability in Hospitals. Adopted.

This resolution encourages Michigan hospitals to develop child care centers to be in operation in or near their facility, to be affordable, to be appropriately staffed, to have flexible hours, and to allow medical students, resident physicians, and practicing physicians to have access to these programs for their children.

This resolution was referred to the MSMS Hospital Medical Staff Section Governing Council for implementation. This resolution was considered by the Governing Council, which determined that this resolution was substantive, and the Michigan Hospital Association, and its member hospitals would be equally as interested, and share the same concerns as do Michigan physicians. In October of 1991, this resolution was forwarded to the Michigan Hospital Association wherein the MHA Board assigned this resolution to the appropriate MHA committee for implementation.

7-91A

Title: Equal Pay for all Physicians. No Action.

8-91A

Title: Michigan Physicians in the Military Reserves. Adopted as Amended.

This resolution was developed in response to the War with

Continued on following page

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

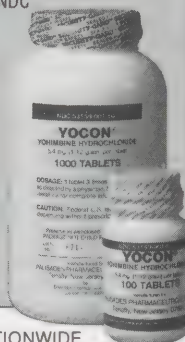
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Iraq and requested that MSMS develop strategies/guidelines for physicians who must be absent from their practice temporarily for any unplanned circumstances. MSMS is working with the AMA and the Physician Service Group to compile an effort of this nature.

9-91A

Title: Bottle and Can Recycling. Adopted as Amended.

This resolution called on MSMS to ask the AMA to encourage Congress to tie all federal funding for state highways to bottle/can deposit laws.

The Michigan Delegation to the AMA introduced a resolution to this effect at the 1991 AMA Interim Meeting. The AMA delegates voted not to adopt this resolution.

10-91A

Title: Curbside Recycling. Adopted as Amended.

This resolution asked that MSMS encourage the state legislature to require all public/private garbage collection businesses to offer curbside (residential) recycling pickup services to their subscribers at reasonable intervals of time as part of their basic services.

MSMS has written to the members of the State Senate Select Committee on Re-use, Recycling and Return of Materials urging them to require all garbage collection businesses to offer curbside recycling pickup services.

The third resolved of this resolution calls on MSMS to ask the AMA to expand existing policy to encourage Congress to require state governments to enact recycling policies in an effort to promote effective recycling of solid waste.

The Michigan Delegation to the AMA introduced a resolution to this effect at the 1991 AMA Interim Meeting. The AMA delegates voted not to adopt this resolution.

11-91A

Title: Health Insurance for Adopted Children. Adopted as Amended.

The first Resolved of this resolution asked that MSMS support Michigan House Bills 4119, 4120 and 4121, that would extend health insurance benefits to adopted children as they are extended to biological children, with these benefits beginning at the date of placement and covering any and all pre-existing conditions.

MSMS has formally submitted a letter to the members of the House Public Health Committee in support of this legislation. MSMS will continue to work for the passage of this legislation.

The second Resolved of this resolution called on MSMS to ask the AMA to encourage Congress to formulate legislation that would extend health insurance benefits to adopted children as they are extended to biological children, with these benefits beginning at the date of placement and covering any and all pre-existing conditions.

The Michigan Delegation to the AMA introduced a resolution to this effect at the Interim Meeting of the AMA House of Delegates. The AMA delegates adopted a substitute resolution calling on the AMA to study the issue of limits on health insurance benefits available for adopted children, as well as appropriate remedies, as needed. The AMA delegates called for a follow-up report at the 1992 Interim Meeting of the AMA House of Delegates.

12-91A

Title: HIV Testing After Accidental Exposure of Health Care Workers. Substitute Resolution (in lieu of 12-91A and 105-91A). Adopted.

This resolution requested that MSMS support legislation that would broaden the exemption from the informed consent requirement for HIV testing under PA 488 to include all exposed health care workers in all outpatient settings.

MSMS contacted staff of Representative Bennane (D-Detroit), Chairman of the House Public Health Committee, concerning this resolution. To date, no legislation has been introduced in this session of the state legislature that would address this resolution. MSMS is seeking amendments to HB 5061, the mandatory AIDS testing bill, introduced by Representative Jaye, to address this resolution.

13-91A

Title: Young Physicians Section (YPS) Delegate Funding. Referred to the Board for Study.

This resolution asked that MSMS fund all delegates and alternates from the MSMS Young Physicians Section to the AMA-Young Physicians Section Interim and Annual Assembly Meetings.

The Board of Directors studied this resolution and concluded that providing funding for an additional delegate and alternate to the AMA Young Physician Section meetings will enhance the continuation of organized medicine. The FY 1992 Budget includes funds to send all four delegates and alternates to the AMA meetings.

14-91A

Title: Elimination of Health Insurance for Pre-Existing Conditions. Adopted as Amended.

The resolution asks for MSMS to investigate the problem of pre-existing conditions and to make recommendations to appropriate state agencies regarding potential changes.

MSMS has examined information available through the Michigan Insurance Bureau about pre-existing condition exclusions in several types of insurance policies and determined that exclusions impact both access to services and the cost of care. Many group policies, particularly those purchased by small employers, exclude coverage for pre-existing chronic conditions and/or catastrophic illnesses, forcing large out-of-pocket expenses for insured individuals. Individual policies may cover these conditions, but often the cost of the insurance is prohibitive. With very limited exceptions, these exclusions are permitted under Michigan law and the Insurance Bureau has no authority to prohibit insurers from including pre-existing condition exclusions in their policies. MSMS will examine possible steps to eliminate the problems created by pre-existing condition exclusions. One step is to seek legislation prohibiting exclusions; the second would be to educate employers purchasing coverage on the cost-effectiveness of covering chronic pre-existing conditions.

15-91A

Title: Level I Trauma Center Support. Disapproved.

16-91A

Title: Toxic Waste Disposal. Adopted as Amended.

The resolution asks that MSMS encourage the establishment of state and local programs for the collection of toxic wastes. The informal survey of county health departments suggests that virtually all Michigan counties have toxic waste disposal

programs available, although most are not well publicized, since some do not have the resources to collect large amounts of waste. The Task Force on Environment and Health will explore means of publicizing this information in cooperation with local agencies.

17-91A

Title: Radon Information. Adopted as Amended.

This resolution calls for MSMS to publicize information about testing for, and controlling, radon accumulation and other indoor environment pollutants.

MSMS has worked with the American Lung Association to publicize information about radon testing and radon control. The MSMS Task Force on Environment and Health has established a subcommittee on indoor environments to further examine indoor pollutants and recommend specific measures for their control.

18-91A

Title: Elimination of Heavy Metals and Benzene. Referred to the Board for Study.

This resolution directs MSMS to seek elimination of mercury, lead and benzene in paint and other products.

The Task Force on Environment and Health is reviewing new federal standards on lead to determine what steps MSMS should take in seeking elimination of metals from paint and other products. Specific recommendations for MSMS action will be presented to the Board of Directors for transmittal to the House of Delegates in May.

19-91A

Title: Chemical Spills. Adopted as Amended.

This resolution calls upon each Michigan hospital with emergency facilities to have in place specific plans to care for the victims of accidental release of chemicals. In particular, it calls for hospitals to be familiar with the manufacturing plants in their vicinity that could accidentally discharge specific chemicals, and be prepared for accidents caused by these chemicals.

This resolution was referred to the MSMS Hospital Medical Staff Section Governing Council for implementation. This resolution was considered by the Governing Council, which determined that this resolution was often, and the Michigan Hospital Association, and its member hospitals would be equally as interested, and share the same concerns as do Michigan physicians. In October of 1991, this resolution was forwarded to the Michigan Hospital Association wherein the MHA Board assigned this resolution to the appropriate MHA committee.

20-91A

Title: Per Claim Participation with BCBSM. Substitute Resolution (in lieu of 20-91A and 98-91A). Adopted.

This resolution asked that MSMS in recognition of patient needs, investigate ways to challenge the interpretation of Public Act 350 of 1980 requiring physicians accept assignments on all similar procedures for the remainder of the year. Senator Joe Schwarz (R-Battle Creek) has introduced legislation (Senate Bill 432) that would make a number of administrative changes within BCBSM. Specifically, SB 432 would eliminate the requirement for per case participation by physician providers. MSMS testified in support of this legislation.

Continued on following page

MSMS will continue to seek passage of this legislation. Senate Bill 432 is still pending before the Joint Senate Commerce and Health Policy Committee.

Additionally, the House of Representatives has recently appointed a special committee to study BCBSM issues. MSMS will be working with this committee to address all of our concerns related to BCBSM. MSMS anticipates that specific legislation will develop from these hearings.

21-91A

Title: Anonymity of Review. Substitute Resolution (in lieu of 21-91A and 28-91A). Adopted.

This resolution, passed in substitute form, called on MSMS, in concert with the AMA, to encourage review organizations to identify the specific physician reviewers responsible for the case review.

The Michigan Delegation to the AMA determined that it already is AMA policy to work to assure that quality of care decisions are made by identifiable peer review organization reviewers. Therefore, no further action was needed.

22-91A

Title: Proper Definition of Physician or Surgeon. Disapproved.

23-91A

Title: Retired Physicians. No Action.

24-91A

Title: Physician Call to Military Leave. Disapproved.

25-91A

Title: Evaluation of Political Candidates. Adopted as Amended.

The first Resolved of this resolution calls for MSMS publications to publish statewide political candidates' written responses to specific questions regarding issues with impact on the public health and the practices of medicine.

Michigan Medicine continues its practice of profiling political leaders. In those profiles, legislators are asked questions about their stands on issues. During 1992, a political campaign year, the magazine staff plans to setup up its coverage of candidates, polling them on issues, and otherwise increase its coverage of health-related campaign issues.

This resolution asked that MSMS use its existing publications to publish statewide political candidates written responses to specific questions regarding issues that may have impact on the public health and the practice of medicine in Michigan. And it further asks that county medical societies solicit similar information on local candidates for dissemination through their publications.

Each year, MSMS solicits responses from every lawmaker on questions regarding health related legislative issues and publishes their responses in its *Michigan Medicine* over the course of a year. MSMS will continue to publish the responses of the State Legislature on questions pertaining to the practice of medicine and general health care issues. MSMS will also continue to work with its county medical societies in an effort to publish this information on the county level.

26-91A

Title: Laser Surgery. Adopted as Amended.

This resolution asked that MSMS ensure that invasive and

non-invasive laser surgery be performed by a licensed doctor of medicine or osteopathy who is trained in laser surgery procedure.

As introduced, HB 4407 included a provision that would have allowed optometrists to perform laser surgery. MSMS was successful in deleting this provision in HB 4407, which has passed the House and is pending in the Senate Health Policy Committee. MSMS will continue to oppose efforts of the optometrists to perform laser surgery. MSMS also has written to the Michigan Board of Medicine urging it to require that laser surgery be performed by a licensed MD or DO trained laser surgery.

27-91A

Title: Consolidated Omnibus Budget Reconciliation Act Program (COBRA). Disapproved.

28-91A

Title: Michigan Peer Review Organization (MPRO) Review. Substitute Resolution (in lieu of 21-91A and 28-91A). Adopted. See Resolution 21-91A.

29-91A

Title: Post-Operative Care. Referred to the Board for Study.

This resolution requests that MSMS support the position that post-operative care must be provided by the operating surgeon or an equivalently trained and licensed physician.

The MSMS Board of Directors has approved an action report that supports this resolution.

30-91A

Title: New Policies of the Michigan Board of Medicine. Adopted as Amended.

This resolution requests that MSMS strongly protest the decision by the Michigan Department of Commerce to no longer provide verbal or written confirmation of current physician licensure to hospital staff offices.

MSMS staff discussed this issue with staff of the Department of Commerce, formerly the Department of Licensing and Regulation. In order to satisfy MSMS concerns, the Department has implemented a new 900 number that hospital medical staff offices can call to verify physician licensure. A charge of \$1.50 per minute will be assessed.

31-92A

Title: Broaden Continuing Medical Education Credits (CME's). No Action.

32-91A

Title: Support for the Appeal of the Determining Report on the BCBSM Medical Doctor Provider Class Plan. Referred to the Board for Study.

The resolution asks MSMS to contribute financial and other support to the appeal of the BCBSM 1987-88 Medical Doctors Providers Class Plan.

Since this resolution was introduced in May, 1991, the Insurance Bureau's Independent Hearing Officer has issued a decision in the appeal. The decision overturned the Insurance Commissioner's determination that BCBSM had met goals relating to cost, quality and access and order BCBSM to develop a new Provider Class Plan. Subsequent action by BCBSM has moved the case into the Michigan Court of Appeals, where the order for a new plan was stayed.

MSMS has supported the appeal through the provision of depositions and background information to the petitioners' attorneys and through informing members how they can contribute. In January, the MSMS Board of Directors voted to recommend to the House of Delegates that we continue this non-financial support, but that we not contribute direct financial support, but that we not contribute direct financial assistance to the appeal. The Board made this decision based on concerns that direct financial support would take financial resources away from other MSMS priorities and would jeopardize our ability to seek improvements from BCBSM while the appeal is pending.

MSMS has created a Task Force on the BCBSM Provider Class Plan to develop recommendations for a new plan. The Task Force includes representation from the MSMS Liaison Committee with BCBSM and from physicians who have supported the appeal. Recognizing the importance of the work that has gone into the appeal, MSMS also has sought input in the provider class plan from the petitioners' attorneys, who are being compensated for their time and expenses in this effort.

33-91A

Title: Nursing Scope of Practice. Substitute Resolution (in lieu of 33-91A, 55-91A and 56-91A). Adopted.

This resolution asked that MSMS oppose the delivery of medical services by independent nurse practitioners. It also asked that MSMS encourage the Michigan Department of Public Health (MDPH) to review nursing policy manuals in each hospital to assure that statements related to the nursing scope of practice, professional philosophy, and mission defined therein are consistent with the laws of the State of Michigan.

MSMS worked closely with the Michigan Medical Services Administration (MSA) to ensure that a certified family and pediatric nurse practitioners cannot independently diagnose and treat Medicaid patients. The policy adopted by the MSA provides that nurse practitioners receive direct reimbursement only for services performed pursuant to a written collaborative practice agreement with a physician.

Blue Cross Blue Shield of Michigan (BCBSM) has expressed interest in providing direct reimbursement to nurse practitioners similar to what Medicaid is providing. MSMS will continue to work closely with BCBSM to ensure that nurse practitioners are reimbursed only for services performed pursuant to a written collaborative practice agreement with a physician.

34-91A

Title: Identify Illustrations of Defensive Medicine. Referred to the Board for Study.

This resolution asked that MSMS undertake a study of "defensive medicine" and its cost impact on total health care costs and its effect on physicians behavior.

That MSMS Board of Directors has approved an action report that urges MSMS and AMA not to conduct a study of defensive medicine, but instead to solicit examples of defensive medicine from physicians.

35-91A

Title: Mandatory Malpractice Insurance. Adopted as Amended.

This resolution asks that MSMS reiterate its strong resolution to mandatory malpractice insurance, even if such insurance is tied to a cap on damages or to any other tort reforms.

MSMS has succeeded in having medical liability reform legislation (SBs 248-249) pass the Michigan Senate on 1991. In addition, medical liability reform legislation (HBs 5434-5435) has been introduced in the Michigan House of Representatives. None of these bills includes mandatory malpractice insurance. However, SBs 185-186, introduced by Senator Jack Faxon (D-Farmington Hills), would require all physicians to participate in a physicians liability association as a condition of licensure. MSMS opposes SBs 185-186. No hearings have been held on SBs 185-186.

36-91A

Title: Support for the Michigan Model Health Care Curriculum. Adopted as Amended.

This resolution asks MSMS to support and provide assistance to the Michigan Model for Comprehensive School Health Education.

MSMS continues to work with the State Bar of Michigan, Michigan State Police, Office of Substance Abuse Services, Michigan Association of School Administrators, Michigan Association of School Boards and Michigan Department of Education in developing medical-education-lawyer-law enforcement teams to present anti-drug programs in Michigan schools. This is an expansion of the successful MELL-Team Against Drugs effort held in the Detroit Schools in the fall of 1990.

When feasible, these programs are being incorporated into the school's Michigan Model curriculum. However, administration of the Michigan Model currently is under review by the Governor's Office. Until a decision is made regarding which Department will implement the Model, MSMS will continue working with its existing contacts.

37-91A

Title: Medical Insurance Overhead Costs. Adopted.

This resolution called on MSMS to ask the AMA to vigorously pursue a simplified medical billing system for all third party payers.

The Michigan Delegation to the AMA submitted a resolution to this effect at the 1992 Interim Meeting of the AMA House of Delegates. The AMA delegates referred the resolution to the AMA Board of Trustees. The AMA Board has referred the resolution to the AMA Council on Medical Service, which is expected to report back at the October 1992 meeting of the AMA Board.

38-91A

Title: Public Information Campaign to Michigan Consumers. Referred to the Board for Study.

This resolution requested MSMS to expand its current "43 cents on the Dollar" campaign concerning Medicaid funding and also requested that MSMS physicians educate their patients about the negative effects of Medicaid budget cuts and encourage them to write their legislators.

The MSMS Board of Directors has approved an action report supporting continuation of the "43 Cents on the Dollar" campaign.

39-91A

Title: Shortage of Public Health and Preventative Medicine Physicians in Michigan. Adopted as Amended.

Continued on following page

This resolution asked MSMS to strongly urge the Michigan Department of Public Health (MDPH), the University of Michigan (U of M) and appropriate others, to take the necessary actions to re-institute the model Public Health and Preventive Medicine Residency Training Program at the U of M School of Public Health.

MSMS has written to the MDPH and the U of M asking that the model Public Health and Preventive Medicine Residency Training Program be re-instituted. Neither the MDPH nor U of M has responded. MSMS will continue to urge these entities to reinstitute the Model Public Health and Preventive Medicine Residency Training Program.

40-91A

Title: Disabled Physicians Survey. Adopted as Amended.

This resolution requests MSMS to conduct a survey to ascertain the incidence and nature of physical disabilities of its members, determine if any special services are needed as a result of these disabilities, and that the results of the survey be referred to an appropriate committee for study and appropriate follow through.

The Steering Committee on Program to Assist Impaired Physicians has created a Subcommittee on the Disabled Physician. This Subcommittee currently is developing a survey form that will be circulated to the membership. The results of the survey will be tabulated and the data submitted to the MSMS Board of Directors along with recommendations from the Steering Committee regarding future courses of action.

41-91A

Title: Equal Access for Physically Challenged Physicians. Adopted.

This resolution calls for Michigan hospitals to adopt guidelines for equal access to all hospital facilities for physically challenged physicians. These hospitals and their medical staffs are encouraged to work with physically challenged physicians to enable them to maximize their utilization of hospital facilities.

This resolution was referred to the MSMS Hospital Medical Staff Section Governing Council for implementation. This resolution was considered by the Governing Council, which determined that this resolution was substantive, and the Michigan Hospital Association, and its member hospitals would be equally as interested, and share the same concerns as do Michigan physicians. In October of 1991, this resolution was forwarded to the Michigan Hospital Association wherein the MHA Board assigned this resolution to the appropriate MHA committee.

The third Resolved of this resolution called on MSMS to recommend to the AMA that it adopt, as part of the standards of the Joint Commission on Accreditation of Healthcare Organizations, guidelines for equal access to all hospital facilities for physically challenged physicians.

The Michigan Delegation to the AMA submitted a resolution to this effect at the 1992 Interim Meeting of the AMA House of Delegates. The AMA delegates adopted the resolution.

42-91A

Title: Who Sues. No Action.

43-91A

Title: County Medical Care Facilities (CMCF's) Mission and Funding. Substitute Resolution (in lieu of 43-91A and 44-91A). Adopted.

The first Resolved of this resolution called upon the Committee on Aging and the County Medical Societies to actively participate in expanding the mission of County Medical Care Facilities (CMCF's) to provide long-term care to the elderly.

The MSMS Committee on Aging, has written to the president of each county medical society in whose a county, a CMCF is in operation, requesting the county society president to establish a liaison with the CMCF Board and Administration. The purpose of this liaison is to encourage them to expand their mission and service to provide long-term care for the elderly, and to offer the expertise of society members in addressing this matter.

The second resolved of this resolution requested that MSMS oppose reductions in state funding for county medical care facilities.

State funding for the Wayne County medical care program, as well as for the indigent care services in the remaining counties in the state, was terminated when Attorney General Kelley ruled that Public Act PA 197 is unconstitutional. MSMS is working to have the legislature continue state funding for the Wayne County Medical Care Program.

44-91A

Title: County Medical Care Facilities (CMCF's) A State Asset. Substitute Resolution (in lieu of 43-91A and 44-91A). Adopted. See Resolution 43-91A.

45-91A

Title: Funding for Regional Poison Control Centers. Adopted.

This resolution requested that MSMS focus efforts to maintain funding for the Regional Poison Control Centers.

The Legislature passed a bill that included \$100,000 in funding for the Regional Poison Control Centers for the 1991-1992 fiscal year. However, Governor Engler vetoed the bill due to budget concerns.

MSMS continues to work for state funding for the Regional Poison Control Centers.

46-91A

Title: Fair and Equitable Reimbursement for Medicaid. Disapproved.

47-91A

Title: Physician "Supersignature." Disapproved.

48-91A

Title: Signing Physician's Orders. Disapproved.

49-91A

Title: Requirements for CME Accreditation. Substitute Resolution 49-91A. Adopted.

This substitute resolution calls for MSMS to explore through appropriate channels, ways to cut down the amount of burdensome paperwork associated with statewide organizations becoming accredited CME providers and that the process begin with a re-examination of the requirements for "mission statements," "needs assessments" and "educational objectives."

The MSMS Committee on CME Accreditation is required to follow guidelines set by the Accreditation Council for Continuing Medical Education when surveying statewide organizations for accreditation. Any changes in ACCME guidelines would have to be submitted for approval by all its member groups. The MSMS Committee will discuss the proposal for recommended changes in the ACCME guidelines at a future meeting.

50-91A

Title: Health Care Administration Cost Cap. Referred to the Board for Study.

This resolution asks that MSMS seek statewide legislation capping administrative health care expenses at 10 percent and that MSMS ask the AMA to seek similar legislation at the federal level.

The Committee on State Legislation and Regulations reviewed this resolution on February 5, and recommended that MSMS support efforts to require third-party payors to cap administrative health care costs at 10 percent. However, the Committee expressed concern of introducing state legislation that does not address federal mandates. Therefore, the Committee strongly suggests that MSMS first work with the AMA in developing model legislation to achieve this goal.

The second resolved of this resolution called on MSMS to ask the AMA to seek legislation at the federal level similar to state legislation capping administrative health care expenses at 10 percent within our pluralistic system.

At its March 18, 1992 meeting, the MSMS Board of Directors amended and approved a resolution to cap administrative expenses for all third party payors at 10 percent. The Board has directed MSMS to work with the AMA in developing model legislation that would achieve this goal. MSMS has contacted the AMA in initiating the process for development of model legislation.

51-91A

Title: Physician Payment for Administrative Requirements Pertaining to Non-Ambulatory Home Health Care Patients. Adopted as Amended.

The resolution asks MSMS to seek payment for physicians' clinical and administrative services for home health care patients.

The resolution was reviewed by the MSMS Liaison Committee with Blue Cross Blue Shield of Michigan who determined that action on this issue was needed to occur at the federal level. The Michigan Delegation to the AMA was one of several delegations offering a resolution calling for Medicare payment for services related to home health care. The delegation is now monitoring AMA progress on this issue.

52-91A

Title: Environmental Concerns of Non-Reusable Materials. Adopted as Amended.

The resolution called for MSMS to take measures to encourage use of reusable supplies and materials in hospitals and other health care facilities.

The Michigan Hospital Association has agreed to cooperate with MSMS in this effort and is collecting information on programs initiated by their members to purchase reusable materials and supplies. When the information is complete, the MSMS Task Force on Environment and Health will share the

information along with suggestions to MSMS Hospital Medical Staff Section representatives.

This resolution calls for medical staffs of health care facilities to meet with their administrations, purchasing, central supply, laundry, and nursing services to consider the advantages and disadvantages of using reusable items in their facilities. Also, that MSMS communicate with the Michigan Hospital Association to stimulate joint discussions to consider environmental concerns in the purchase, usage, and disposal of non-recyclable materials used in hospitals.

This resolution was referred to the MSMS Hospital Medical Staff Section Governing Council for implementation. This resolution was considered by the Governing Council, which determined that this resolution was substantive, and that the Michigan Hospital Association, and its member hospitals would be equally as interested, and share the same concerns as do Michigan physicians. In October of 1991, this resolution was forwarded to the Michigan Hospital Association wherein the MHA Board assigned this resolution to the appropriate MHA committee.

53-91A

Title: Alternative Usage of Acute Care Beds. Adopted.

This resolution asks MSMS to seek legislation to allow hospitals flexibility to use their acute care beds for alternative care, without the threat of losing these beds for acute care status.

MSMS was successful in passing legislation (Public Act 259 of 1990) that allows hospitals to use their acute care beds for alternative uses, without going through the Certificate of Need (CON) process.

54-91A

Title: Michigan Peer Review Organization (MPRO) Accept Collect Calls from Physician Offices for MPRO Medicare Pre-admission/Pre-procedure Authorization Review (PAR) Program. Adopted as Amended.

This resolution calls upon MSMS to bring about access to physician reviewers when seeking a Pre-Admission/Pre-Procedural approval for Medicare patients at no cost to the attending physician.

This resolution has been addressing insofar as the Medicare Fourth Scope of Work to be implemented in Michigan on April 1, 1992, called for the elimination of the Pre-Admission/Pre-Procedure Authorization Program. Because of this, and because several states implemented the Fourth Scope of Work on October 1, 1991, the Michigan Peer Review Organization determined to conclude the PAR Program in Michigan on October 1, 1991.

55-91A

Title: Nursing Scope of Practice. Substitute Resolution (in lieu of 33-91A, 55-91A and 56-91A). Adopted. See Resolution 33-91A.

56-91A

Title: MSMS/HMSS Oppose the Independent Practices of Nurses. Substitute Resolution (in lieu of 33-91A, 55-91A and 56-91A). Adopted. See Resolution 33-91A.

57-91A

Title: Change Confidentiality Rules for HIV Positive Patients. Adopted as Amended.

Continued on following page

This resolution asked that MSMS seek legislation which would place HIV testing in the same category as all other laboratory testing by eliminating the informed consent requirements for such testing.

In August 1991, Representative David Jaye introduced legislation (House Bill 5062) that would require both health care providers and health care recipients to submit to an HIV test. Patients would have to be tested prior to undergoing an invasive procedure and health care workers would have to be tested every six months.

While this bill eliminates the requirement for informed consent, as this resolution (57-91A) specifies, the MSMS Committee on State Legislation and Regulations recommend to the Board of Directors that MSMS oppose this legislation due to the high cost involved in mandatory testing and the inaccuracy of testing every six months.

58-91A

Title: Reconsider Joining AMA National Credentials Verification Service. Referred to the Board for Study.

This resolution asks that MSMS reconsider joining the AMA National Credential Verification Service.

The MSMS Board of Directors has appointed a task force to work with the Michigan Hospital Association and the Michigan Society of Osteopathic Physicians and Surgeons to determine the feasibility of creating a Centralized Credentialing Verification Program in Michigan. The task force met on several occasions and plans to have the recommendations to the respective Boards of the three association's in early Spring of 1992. In order for a Centralized Credentialing Verification Program to work in Michigan, the task force has determined several actions must be taken. First, legislation specifically allowing for the extension of confidentiality of the information held by the corporation must be enacted. MSMS and MHA Government Relations Departments currently are working on an amendment to the current peer review statutes. Second, a feasibility survey has been sent out to hospital administrators and a random sample of physicians, to determine the interest for such a program in Michigan. Both hospital administrators and physicians indicated a positive response to such a service. Third, a task force is studying other states where a Centralized Credentialing Verification Program has been established to determine the characteristics of their successful programs.

Once the task force has completed its work regarding the legislative marketing and organizational structure of the program, if the association's Boards approve, the program will move forward under the auspices of a separate corporation jointly held by MSMS and MHA and MAOP&S.

59-91A

Title: Control MSMS Dues. Adopted as Amended.

This resolution asked that MSMS re-evaluate its policy of dues increases for three-year periods, and consider dues increases, if necessary, be done incrementally each year.

The Ways and Means Committee is reviewing the current three-year dues cycle for FY 1991 - FY 1993 and will report to the 1992 House of Delegates.

The MSMS Strategic Planning Committee concluded its year-long review of MSMS programs and expenditures in the fall of 1991 and the final plan was adopted by the Board of Directors.

The plan specifically identified areas of reducing expenditures and increasing non-dues income. A complete copy of the plan is available from MSMS.

60-91A

Title: Physician Information on Late Reports. Adopted as Amended.

This resolution calls upon MSMS to work with the Michigan Hospital Association to develop and implement mechanisms to inform physicians of medical reports filed on the medical record after the patient is discharged.

The resolution was referred to the MSMS Hospital Medical Staff Section Governing Council for implementation. This resolution was considered by the Governing Council, which determined that this resolution was substantive, and that the Michigan Hospital Association, and its member hospitals would be equally as interested, and share the same concerns as do Michigan physicians. In October of 1991, this resolution was forwarded to the Michigan Hospital Association wherein the MHA Board assigned this resolution to the appropriate MHA committee.

61-91A

Title: Malpractice Mediation II. Adopted as Amended.

This resolution asked that MSMS urge the Michigan Supreme Court to amend MCR 2.403 to provide that health care professionals selected as mediators must receive the full medical record for review at least 14 days prior to mediation and that enforceable financial sanctions be imposed against attorneys who do not provide the full medical record in a timely manner.

MSMS has written to the Michigan Supreme Court urging it to amend the rules to satisfy this resolution. To date the Supreme Court has not responded.

62-91A

Title: Malpractice Mediation. No Action.

63-91A

Title: Renew AMA International Medical Graduates' Advisory Committee. Adopted.

This resolution called on MSMS to request the AMA Board of Trustees to renew the AMA Advisory Committee for International Medical Graduates for at least two more years, to give the Committee more time to complete its work.

The AMA Delegation wrote a letter to this effect to the AMA Board of Trustees. The AMA Board voted in October to continue the Advisory Committee another two years.

64-91A

Title: Payment of Physician's Services for Patients in Observational or Short Stay Units. Adopted as Amended.

The second Resolved of this resolution called on the Michigan Delegation to the AMA to request the AMA to take appropriate action to obtain payment for physicians' services when patients are appropriately managed in short stay units or observational status.

The Michigan Delegation to the AMA introduced a resolution to this effect at the 1991 AMA Annual Meeting. The AMA delegates adopted the resolution.

65-91A

Title: Elimination of Pre-Procedural Review. Adopted as Amended.

This resolution calls for MSMS to seek elimination of pre-procedural and pre-admission review requirements in Michigan and to ask the AMA to seek elimination of the same requirements for Medicare.

MSMS has been active in seeking elimination of pre-admission review requirements. In 1991, Medicare eliminated pre-procedural review requirements for several procedures. Blue Cross Blue Shield of Michigan eliminated over 800 procedures from pre-authorization requirements in response to strong concerns voiced by MSMS. Despite widespread acknowledgement that such programs cost more than they save, many large purchasers in Michigan continue to insist upon pre-procedural review as a cost containment measure. In 1992, MSMS will begin discussion of these requirements through the BCBSM Physician Contract Advisory Committee, which includes representation from Michigan's major purchasers of health care coverage. Through that process, we hope to educate the purchasers about the inefficiency of these pre-procedural and pre-admission review requirements, with the goal of eliminating the requirements entirely.

The second Resolved of this resolution called on the Michigan Delegation to the AMA to seek immediate elimination of the Medicare pre-procedural and pre-admission review.

The Michigan Delegation to the AMA introduced a resolution to this effect at the 1991 AMA Annual Meeting. The AMA delegates approved this resolution on affirmation.

66-91A

Title: Medical Student Section Communications. Adopted.

This resolution requested that MSMS develop a newsletter for the Medical Student Section (MSS) with assistance of the Medical Student Section Governing Council and that the newsletter be used for membership recruitment purposes. The MSS Governing Council will be submitting articles for publication and working with the Communications Department to develop this project. The MSS Governing Council anticipates publishing a newsletter at least twice a year.

67-91A

Title: Physician Appointments to Health Care Committees. Adopted.

The first Resolved of this resolution called on MSMS to request the AMA to appoint to health policy committees for private and governmental studies only those physicians who are members both of the AMA and of their state medical societies.

The Michigan Delegation subsequently mailed a letter to AMA EVP James Todd, MD, requesting that the AMA follow this policy.

68-91A

Title: Medical Practice Standards Set by Insurance Companies. No Action.

69-91A

Title: Rejection of Continuing Medical Education (CME). Adopted as Amended.

This resolution asked that MSMS encourage providers of CME programs to offer their courses at a fee equal to or less than estimated costs, and recommend that the Accreditation Council on Continuing Medical Education take similar action.

Correspondence being sent to providers of CME programs approved for joint-sponsorship by the MSMS Committee on CME Programming has been revised to include a statement regarding the value of providing CME programs for reasonable, at-cost fees when possible. A letter has been sent to the ACCME recommending similar wording.

70-91A

Title: Student Loan Endowment Fund. Referred to the Board for Study.

This resolution asked that MSMS create a Student Loan Endowment Fund.

The Health Education Foundation studied this resolution and reported to the Board that the experience of the Foundation with its former program of student loans was unsatisfactory and consideration of establishing a new student loan fund is beyond the scope of the Foundation's mission and scope of activities.

71-91A

Title: Subrogation Lien Rights of BCBSM in Medical Malpractice Cases. Adopted.

This resolution directed MSMS to introduce legislation banning subrogation lien rights by third party health insurers and give full support toward successful passage of such legislation.

As noted earlier, Senate Bill 432 was introduced by Senator Joe Schwarz (R-Battle Creek) which would amend Public Act 350 to ban subrogation lien rights by third party health insurers. MSMS will continue to work for passage of this legislation.

72-91A

Title: Opposition to Discriminatory Practices. Substitute Resolution (in lieu of 72-91A and 78-91A). Adopted.

This resolution, adopted in substitute form, called on the AMA for action, without indicating a desired role for MSMS, leadership consulted with leaders of the MSMS for International Medical Graduates for direction. In August, MSMS mailed letters to Michigan congressmen seeking their support for recently introduced federal legislation banning discrimination against international medical graduates.

73-91A

Title: Develop Michigan Externship Programs for the International Medical Graduates (IMGs). Referred to the Board for Study.

This resolution called on MSMS to explore ways to work with interested groups to provide externship programs for IMGs so that they can be accepted into training programs. This resolution was referred to the Board for study. At its March 18 meeting, the Board adopted a report from Executive Director William E. Madigan in lieu of Resolution 73-91A. The report, which will go to the 1992 MSMS House of Delegates meeting, recommends that MSMS not pursue such externships. The report notes that MSMS already is working extensively to assist IMGs to obtain residencies through several avenues, including a Match Day follow-up, and seminars to build interview skills and to help IMGs speak English more understandably.

Continued on following page

74-91A

Title: Monthly Column in JAMA for International Medical Graduates (IMG's). Adopted as Amended.

This resolution called on MSMS to request the AMA Advisory Committee on IMGs to encourage the Editorial Board of JAMA to publish a monthly column on issues of interest to IMGs.

In June, 1992, JAMA Editor George Lundberg, MD, met with the AMA Advisory Committee. He told them he could not commit a column to IMGs. He suggested the IMGs provide JAMA with story tips, and also prepare a historical overview of AMA IMG activities. Then-staff to the Advisory Committee, John Kasper, prepared the latter for publication in JAMA, while MSMS has been working with Committee Chairman Busharat Ahmad, MD, of Michigan, to prepare a history of the MSMS IMG Section for publication in JAMA.

75-91A

Title: MSMS Aid to International Medical Graduates (IMG's) for Residency Placement Following Match Day. Adopted as Amended.

This resolution called on MSMS to develop a program to assist nonmatched prospective residents in obtaining a residency placement in unfilled Michigan positions following Match Day. The Governing Council of the MSMS Section for International Medical Graduates has proposed a system for providing such a program. The MSMS Board approved its proposal at its January 15 meeting. Plans are underway to expand the post Match Day matchmaking in the Fall of 1992.

76-91A

Title: Residency Program Prejudiced Against Applicants with Ethnic Names. Adopted as Amended.

This resolution called on the Michigan Delegation to the AMA to recommend that the AMA encourage directors of national residency programs to select residents on the basis of their merit and without consideration of an ethnic name as a negative factor.

The Michigan Delegation to the AMA introduced a resolution to this effect at the 1991 AMA Annual Meeting. The AMA delegates adopted the resolution.

77-91A

Title: Study of AMA Section for International Medical Graduates (IMG's). Adopted as Amended.

This resolution calls on MSMS to ask the AMA Advisory Committee for IMGs to explore the development of a Section for IMGs at the AMA level, and for the Michigan Delegation to the AMA to support the efforts of the AMA Advisory Committee for IMGs to establish such a section.

In October, the Michigan Delegation to the AMA wrote AMA EVP James Todd, MD, calling for the AMA to study development of an AMA Section for IMGs, and supporting the AMA Advisory Committee's efforts to establish a section.

78-91A

Title: AMA to Expedite Equality in Licensure. Substitute Resolution (in lieu of 72-91A and 78-91A). Adopted. See Resolution 72-91A.

79-91A

Title: MSMS Representation of Academic Physicians. Adopted as Amended.

This resolution called for better representation by MSMS of the

needs and concerns of academic physicians by providing an open forum for discussion, under the leadership of MSMS.

The groundwork for a forum to discuss concerns of academic medicine was begun four years ago with the establishment of periodic "site visits" with the medical school deans and MSMS leaders. This effort will be expanded to include more practicing academic physicians, department chairmen and newly-elected MSMS leaders. The first discussion group is being scheduled for May, 1992.

80-91A

Title: Comparative Fee Study. Disapproved.

81-91A

Title: True Peer Review. Adopted.

The first Resolved of this resolution calls on MSMS to ask the AMA to request HCFA to require PROs to use specialty-specific reviewers to make all final determinations of appropriateness and quality of care.

The Michigan Delegation to the AMA introduced a resolution to this effect at the 1991 Annual Meeting. The AMA delegates adopted the resolution.

The second Resolved of this resolution calls for the Michigan Peer Review Organization, when it has no reviewer qualified to make a determination in a specific case, to obtain the services of a non-pro physician on a fee-for-service or contractual arrangement to provide "true peer review".

The MSMS liaison Committee with MPRO, forwarded a copy of this resolution to Richard E. Burney, President, MPRO Board of Directors and Karen Douthett-Connolly, RN, Chief Operating Officer, Michigan Peer Review Organization, requesting the review of this resolution by the Board and Administration of the Michigan Peer Review Organization, and that the MSMS Liaison Committee receive a response regarding the resolved portion of this resolution.

82-91A

Title: Medical Research Impact on the Cost of Medical Care. Disapproved.

83-91A

Title: Uniform Licensing of Physicians. Referred to the Board for Study.

This resolution asks that MSMS request the Board of Medicine to develop criteria for uniform licensing of all physicians (allopathic and osteopathic) in Michigan and that MSMS support legislation to ensure uniform licensing requirements of all physicians in Michigan.

The MSMS Board of Directors has approved an action report that recommends that MSMS not support uniform criteria for licensing of physicians.

84-91A

Title: L-glutamic Acid. Adopted as Amended.

This resolution calls on MSMS to ask the AMA to encourage all appropriate regulatory agencies including the FDA, to make labeling mandatory on all foods containing even small amount of the man-made form of L-glutamic acids so that individuals wanting to avoid this substance may do so.

The Michigan Delegation to the AMA introduced a resolution to this effect at the 1991 AMA Annual Meeting. The AMA delegates adopted an amended resolution calling for the FDA

to mandate labeling of all food containing even small amounts of *additive* L-glumatic acid.

85-91A

Title: Philip Morris Bill of Rights Tour. Adopted as Amended.

This resolution called for MSMS to join other groups to coordinate an informational campaign highlighting the serious consequences of tobacco use, to counteract the subliminal messages of the Philip Morris Bill of Rights tour.

During the fall of 1991, MSMS met with a coalition of Michigan organizations providing such information prior to the visit of the Philip Morris exhibit in Detroit. MSMS also began collecting information on the new AMA "Quit for Good" campaign, with plans to have the new Chief of Community Relations coordinate MSMS efforts with that project.

86-91A

Title: Government Mandated Fee Schedules for Automobile No-Fault Insurance. Adopted.

This resolution asks that MSMS request the Michigan Legislature to refrain from enacting laws which would require the use of a government mandated medical fee schedule or a government mandated managed health care system or other restrictions or limitations on medical benefits in automobile no-fault. This resolution also asks that MSMS present a copy of this resolution to the Michigan Senate, the Michigan House of Representatives, and Governor John Engler. A copy of this resolution was provided.

In December 1991, MSMS was successful in defeating proposed legislation that would establish a government mandated fee schedule for no-fault automobile insurance system. MSMS presented formal testimony at each of the hearings held on this legislation strongly opposing the use of mandated fee schedule and provided the State Legislature with a copy of this resolution. In March 1992, the State Legislature passed legislation to reform the current no-fault automobile insurance system. This legislation did not contain any provisions that affect physicians directly. MSMS will continue to closely monitor legislative activities on no-fault automobile insurance. MSMS will continue to oppose mandated fee schedules for the no-fault auto insurance system.

87-91A

Title: Workers Compensation Fee Schedule. Adopted.

This resolution asked MSMS to provide input on Workers Compensation fee schedule and disputes of the same. This resolution also asked MSMS to request the Michigan Legislature to act promptly to eliminate the requirement for the fee schedule from the workers compensation law.

MSMS has created a Task Force on Workers Compensation, chaired by Thomas Harris, MD. This Task Force was created to provide the Department of Labor with a unified physician voice on the workers compensation rules and fee schedule. Richard P. Horsch, MD, was appointed to serve as the MSMS representative on the Workers Compensation Advisory Committee which reviews the rules and fee schedule.

The Workers Compensation Advisory Committee has recently voted for physician payment reform similar to the RBRVS that Medicare just implemented. MSMS will actively monitor this process to ensure physician involvement in the design of the payment formula.

Although MSMS does not support government mandated fee

schedules, MSMS was successful in revising the current workers compensation fee schedule to increase fees by approximately ten percent for physicians.

88-91A

Title: Blue Cross Blue Shield of Michigan (BCBSM) Identification Cards. Adopted as Amended.

This resolution asks that MSMS seek legislation to require that subscribers covered under an Administrative Services Only (ASO) arrangement:

1. Have separate BCBSM identification cards
2. Require that separate physician participating agreements be established for ASO businesses, and
3. To permit employees of ASO customers to stipulate to direct payment of their physicians, regardless of whether they have signed a participation agreement.

Legislation has been introduced in both the Senate (SB 432) and the House (House Bill 5027) that would prohibit BCBSM from performing administrative services only contracts. Currently, this legislation is being considered in committees on both sides. MSMS will continue to work for passage of this legislation.

89-91A

Title: Medicare Carrier. Substitute Resolution (in lieu of 89-91A and 93-91A). Adopted.

This resolution asked that MSMS investigate alternative carriers through which physicians can bill Medicare.

The Liaison Committee with BCBSM's Subcommittee on Medicare Carrier received information on the criteria the Health Care Financing Administration (HCFA) uses in selecting carriers and evaluating performance. HCFA has several criteria, but in light of increasingly tight budgets, the cost per claim processed is very important. HCFA intends to decrease the number of carriers over time eventually and will reward good performers by consolidating other states with those carriers.

The Subcommittee learned that the HCFA Region V office wants information on problems physicians are having with the carrier. Although they evaluate the carrier on many criteria, extreme physician dissatisfaction would have some influence. Two other states, Illinois and Ohio, were contacted about the experience with their carriers. Physicians in both states are upset with HCFA policy, but Ohio has higher regard for its carrier, in part because its health insurance business is mainly Medicare and because of the historical community orientation of the carrier. The Ohio Medical Association is very concerned about the regionalization plan, and they are not at all interested in having their carrier expand any further.

The Subcommittee is recommending to the full Committee that MSMS collect information on problems physicians are experiencing with the carrier via a tearout in *Medigram*. This would allow the Subcommittee to document the volume of problems, evaluate the carriers responsibility in these problems, and inform the HCFA Region V office.

90-91A

Title: Blue Cross Blue Shield of Michigan (BCBSM) Provider Class Plan. Referred to the Board for Study.

This resolution calls for MSMS to seek a comprehensive review of BCBSM practices and to seek provisions in the

Continued on following page

BCBSM Medical Doctors Provider Class Plan that would ensure equitable payment to Michigan physicians.

Early this year, a House Insurance Committee review of BCBSM will begin examination of the Blues' performance in meeting the cost, quality and access goals of their enabling act, P.A. 350 of 1980. MSMS plans active participation in this effort. MSMS has also been acting in sharing physician concerns about BCBSM with the state's Insurance Commissioner. Currently, MSMS has a task force working to develop recommendations regarding provider class plan. These recommendations will address a variety of physician concerns, including reimbursement. They will be shared with state officials, legislators and BCBSM as appropriate.

91-91A

Title: Blue Cross Blue Shield of Michigan (BCBSM) Claims Appeals Process. Referred to the Board for Study.

The resolution directs MSMS to seek legislation to guarantee physicians due process rights in appeals of BCBSM decisions.

MSMS has been active in seeking changes to the appeals process, but the Legislature is only one of several avenues being used to seek appropriate modifications. Legislation introduced in the Senate, SB 432 would require the Blues to have a three step appeals process that includes an informal conference, an opportunity for a hearing before a regional panel of peers and binding arbitration. A House examination of BCBSM practices also is expected to generate interest in Blue's appeals processes.

Recommendations regarding the appeals process are being developed by the MSMS Task Force on the BCBSM Provider Class Plan. These recommendations will be shared with appropriate individuals as the BCBSM Medical Doctors Provider Class Plan comes up for review. MSMS is also seeking changes to the appeals process through the BCBSM Physicians Contract Advisory Committee.

92-91A

Title: Repeal of PA 350 Section 401(6) and Section 502(1)(a) and (b). No action. Withdrawn.

93-91A

Title: Medicare Intermediary. Substitute Resolution (in lieu of 89-91A and 93-91A). Adopted. See Resolution 89-91A.

94-91A

Title: Divestment of Financial Holdings in Tobacco Companies. Adopted as Amended.

This resolution asked that MSMS when feasible refrain from making financial investments in mutual funds with tobacco holdings.

This resolution has been implemented by the Treasurer and the Finance Committee. MSMS has no financial holdings in Tobacco Companies.

95-91A

Title: Medicaid Reimbursement. No Action.

96-91A

Title: Medicaid Reimbursement as a Tax Credit. Disapproved.

97-91A

Title: Medicare Durable Medical Goods Prescribing. Disapproved.

98-91A

Title: PA 350 and the Mandatory Assignments Provision. Substitute Resolution (in lieu of 20-91A and 98-91A). Adopted. See Resolution 20-91A.

99-91A

Title: Medicaid Reimbursement. Adopted.

This resolution requests that MSMS oppose all Medicaid cuts in reimbursement and that payments be increased to a level to cover physician and hospital costs.

MSMS was successful in having the state legislature pass a Medicaid budget for fiscal year 1991-1992 that included a 15 percent increase in Medicaid physician reimbursement. MSMS will continue to oppose cuts in Medicaid reimbursement and will continue to urge the legislature to increase Medicaid physician reimbursement.

100-91A

Title: Medicaid Payments to Physicians. No Action.

101-91A

Title: Peer Review Organization (PRO) Sanctions. Adopted as Amended.

This resolution called for MSMS to vigorously pursue with the Michigan Peer Review Organization: (1) the careful definition of an adverse event; (2) the identification of whether the event is avoidable or unavoidable, or a recognized complication of diagnosis for treatment; (3) whether the event establishes a pattern or trend pointing to inappropriate physician or institutional behavior, and the Michigan Delegation to the AMA requests the AMA to take similar action. It also calls for the requirement that in the absence of evaluation and appropriate identification of "fault" the Michigan Peer Review Organization be limited in its penalty against an attending physician.

The MSMS Liaison Committee with MPRO, forwarded a copy of this resolution to Richard E. Burney, President, MPRO Board of Directors and Karen Douthett-Connolly, RN, Chief Operating Officer, Michigan Peer Review Organization, requesting the review of this resolution by the Board and Administration of the Michigan Peer Review Organization, and that the MSMS Liaison Committee receive a response regarding the resolved portions of this resolution.

102-91A

Title: Preserving Manual Billings. Adopted as Amended.

This resolution asked that MSMS petition Blue Cross Blue Shield of Michigan (BCBSM) and the Health Care Financing Administration (HCFA) to preserve manual billing with no disincentives or punitive measures and that the Michigan delegation submit a similar resolution to the AMA House of Delegates.

A letter was sent to HCFA explaining the burden of expensive computer billing packages on small practices. A HCFA official responded, stating that their long-term goal is to move to electronic billing since it save the program 50 cents per bill compared to paper. They also acknowledged that certain practices may have more difficulty moving to electronic billing (solo practitioners, rural, etc.) and that HCFA is looking for low cost software to make available. They gave assurance that

"clean" paper claims will be processed no later than 30 days from their date of receipt, in accordance with the law. They also stated that there is no policy on allowing the carrier to process electronic claims before paper or to charge for paper claims submission.

A similar resolution was sent to the AMA House of Delegates and adopted as amended.

The second Resolved of this resolution called on MSMS to submit a resolution requesting the AMA to ask HCFA to preserve manual billing on an equal footing with computerized billing.

The MSMS Delegation to the AMA introduced a resolution to that effect at the 1991 AMA Annual Meeting. A substitute resolution passed, calling on the AMA to ask Medicare carriers and HCFA to preserve the option of manual billing on an equal footing with electronic claims submissions, with no disincentives and no punitive measures for physicians who continue to manually bill for Medicare services.

103-91A

Title: MSMS Task Force on Access to Care. Referred to the Board for Study.

This resolution asks for MSMS to create a task force on access to health care.

Several MSMS committees are active in evaluating, monitoring and recommending proposals related to access to health care. The MSMS Advisory Committee on Medical Economics has recommended against establishment of a new task force on this issue, because it is apparent that action on this issue will come at the federal level. The Advisory Committee is currently evaluating several national proposals to determine their impact on the problems of Michigan citizens.

104-91A

Title: Do Not Resuscitate (DNR) Policy. Referred to the Board for Study.

This resolution requesting MSMS to take a more proactive role re Do Not Resuscitate orders was referred to the Committee on Bioethics by the MSMS Board of Directors. After a thorough review of 104-91A, consideration of the provisions of the Patient Advocate Action of 1990 and discussion of the feasibility of hospitals, extended care facilities and other institutions implementing the resolution, the Committee on Bioethics submitted an Action Report to the Board of Directors recommending that MSMS support the following conclusions of the Committee in lieu of the Resolved portions of the resolution:

1. Believes that the Patient Advocate Act of 1990 adequately addresses all the patients' rights issues included in 104-91A.
2. Opposes specific state legislation governing Do Not Resuscitate (DNR) orders alone.
3. Urges MSMS to promote the spirit of 104-91A by efforts to educate all physicians on the effective implementation of the Patient Advocate Act and DNR Orders.
4. Believes that 104-91A, as written, may be counter productive by its emphasis on documentation and legislation.

The above was approved by the Board of Directors.

105-91A

Title: HIV Testing in the Event of Accidental Exposure or Contamination. Substitute Resolution (in lieu of 12-91A and 105-91A). Adopted. See Resolution 12-91A.

106-91A

Title: Opposition to a Radioactive Waste Site in Michigan. No Action.

107-91A

Title: The Need to Enact Strict Water Quality Protection Laws for Great Lakes Water Systems. Adopted as Amended.

The resolution calls for MSMS to initiate actions to protect water quality in the Great Lakes. Representatives of the MSMS Task Force on Environment and Health participated in the Great Lakes Quality conference in 1991. Recommendations from that conference are being distributed to appropriate state legislature and agencies. MSMS has also contacted medical societies in Great Lakes states to determine what activities are underway in other states and in the Province of Ontario. In 1992, the Task Force on the Environment and Health hopes to begin cooperative efforts with other affected states and provinces.

108-91A

Title: Indemnify Michigan Physicians Against Liability for Care of the Indigent. Adopted as Amended.

This resolution asks that MSMS aggressively pursue passage of a law to indemnify Michigan physicians against malpractice suits when care has been provided to Medicaid patients. MSMS is working with Representative Hickner (D-Bay City) to introduce legislation that would implement this resolution. However, Representative Hickner who is co-sponsor of the MSMS liability reform legislation (HBs 5434-5435), has indicated he wants to focus his efforts on comprehensive liability reform.

The second Resolved of this resolution called on MSMS to ask the AMA to pursue passage of federal legislation seeking indemnification of physicians when they provide care to Medicaid patients.

The Michigan Delegation to the AMA introduced a resolution to this effect at the 1991 AMA Annual Meeting. The AMA delegates referred the resolution to the AMA Board of Trustees, which is expected to recommend action at its April 1992 Annual Meeting in June.

109-91A

Title: Defining the Terms "Right to Health Care." No Action.

110-91A

Title: Invitation to Governor Engler to explain to communities why the private sector should step in where the state is stepping away from responsibility. Adopted as Amended.

This resolution asks MSMS to invite Governor Engler and legislative leaders to explain to MSMS members what they expect the role of private sector providers to be in the provision of health care to recipients of Department of Social Services benefits, as well as persons who have been removed from the list of recipient of benefits.

Governor Engler addressed the MSMS Board of Directors at its October 1991 meeting. In addition, despite the severe budget problems faced by the State of Michigan, Medicaid physician reimbursement increased by 15 percent in December 1, 1991.

Continued on following page

111-91A

Title: Proposed Public Relations Campaign in Opposition of Medicaid and General Assistance (GA) Medical Budget Cuts. Disapproved.

112-91A

Title: Removal of Michigan Doctors Political Action Committee (MDPAC) Contribution Solicitation from Dues Statements. Adopted as Amended.

This resolution requested that the MDPAC contribution be identified and separated on the MSMS dues statements. This was accomplished for the 1992 billing cycle which began in October.

It is important to note that MDPAC participation significantly decreased during the 1992 year.

113-91A

Title: Commending the Genesee County Medical Society on its 150th Anniversary. Adopted.

The second Resolved of this resolution calls on MSMS to ask the AMA to commend the Genesee County Medical society on its 150th Anniversary in 1992. The Michigan Delegation to the AMA wrote AMA EVP James Todd, MD, in October 1991 requesting that this be done.

114-91A

Title: Medicaid Funding for Norplant Implants. Adopted as Amended.

This resolution requests that MSMS pursue action through the legislature and the Governor to provide pre-approved Medicaid funding for Norplant implants.

The Michigan Medicaid Program now provides pre-approved funding for Norplant implants for Medicaid patients. MSMS will oppose efforts to change this policy.

115-91A

Title: Therapeutic Optometric House Bill 4407. Not accepted as a Late Resolution.

116-91A

Title: Administrative Services Only Regulations. Adopted as Amended.

The resolution directs MSMS to initiate several activities relative to Premier PLUS, a laboratory PPO established by BCBSM on behalf of one of its self-insured customers. Specifically, the resolution asks for MSMS to seek input from the Insurance Commission on BCBSM actions in creating the PPO and to research the effects of federal preemption of state laws.

Following an Insurance Commissioner's examination of the Blues' actions in establishing Premier PLUS, a notice of opportunity to show compliance with state law was issued to BCBSM. The notice identified several potential allegations of state law. Because the PPO was established for a self-insured customer which is governed by federal law, the Insurance Commissioner may not have any authority to direct the Blues to correct their violations, since the federal law includes a provision preempting state regulations. A final determination from the Insurance Commissioner has not yet been issued.

In related activity, MSMS has closely monitored two lawsuits challenging the establishment of Premier PLUS. A Wayne

County Circuit Court order requires the Blues to comply with certain provisions of state law, but the decision is being appealed. Given the broad implications of this issue and the large amount of self-insured business being administered by BCBSM, MSMS will consider submitting an amicus brief at the appropriate time.

The fourth Resolved of this resolution called on the Michigan Delegation to the AMA to ask the AMA to seek amendments to ERISA that would remove the federal pre-emption of state regulatory of self-funded health benefit plans.

The Michigan Delegation determined in subsequent study that it already is AMA policy to seek removal of federal pre-emption of state regulation of self-funded health benefit plans. No further action was needed.

117-91A

Title: Prescription for Androgenic Anabolic Steroids. Adopted.

This resolution asked MSMS to work with the proper agencies to modify the requirements for the prescribing of androgenic anabolic steroids.

Senator Joe Schwarz (R-Battle Creek) introduced legislation (Senate Bill 398) that would remove certain anabolic steroids from the triplicate prescription reporting requirement.

MSMS actively supported the passage of this legislation. This bill was signed into law by the Governor on December 27, 1991.

118-91A

Title: Nathan Davis Award. Adopted as Amended.

This resolution asked the Michigan Delegation to the AMA to express MSMS delegates' dismay that the Nathan Davis Award is presented in the name of the AMA but without representing the will of the AMA House of Delegates nor the sentiment of its members, called for review of the process of selection of Nathan Davis awardees and the criteria for membership on the selection committee, and asked that the AMA House be informed of any other awards given in the AMA name but devoid of final AMA Board of House approval.

The Michigan Delegation to the AMA introduced a resolution to that effect at the 1991 AMA Annual Meeting. The AMA delegates did not adopt the resolution.

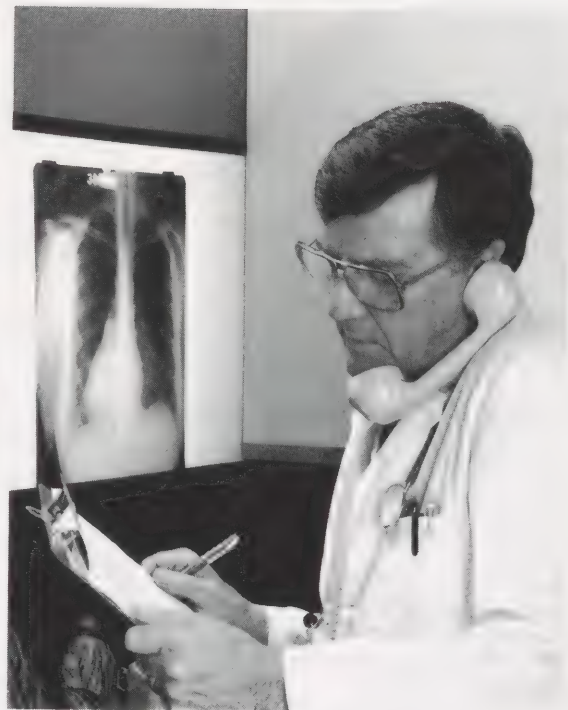
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John H. McLaughlin, MD
B. David Wilson, MD

■ DELEGATES' RECORD OF ATTENDANCE ■

May 1-3

Meeting

OFFICERS

1st 2nd 3rd

Speaker:

Robert D. Allaben, MD X X X

Vice-Speaker:

Gary D. Maynard, MD X X X

Secretary:

Thomas R. Berglund X X X

DELEGATES AND ALTERNATES

ALLEGAN:

Van O. Keeler, MD X X X

ALCONA-PRESQUE-ISLE:

Peter Aliferis, MD X X X

BARRY:

David M. Woodliff, MD - X X

BAY:

Paul L. Chan, MD X X X

Robert C. Prophater, MD X X X

BERRIEN:

Frank H. Bunker, MD X X X

Fred M. Busse, MD X X X

Linda K. Stanley, MD X X X

Edward J. Westerbeke, MD - - -

BRANCH:

Jeffrey C. Custer, MD - X -

CALHOUN:

B. Douglas Campbell, MD X X X

Robert W. Oakes, MD X X X

Paul A. Walk, MD X X X

Michael A. Wozny, MD X X X

CASS:

Boonchoo Chang, MD X X X

CHIPPEWA-MACKINAW:

Jack M. Pahn, MD X X X

CLINTON:

Not Represented

DELTA:

Ali H. Sawaf, MD - - -

DICKINSON-IRON:

Douglas L. Villa - - -

EATON:

Sherman W. Horn, II, MD X X X

GENESEE:

Ali A. Esfahani, MD - - X

Cyrus Farrehi, MD - X X

George H. Greidinger, MD X X X

Edwin H. Gullekson, MD - X -

Vivian M. Lewis, MD - - -

Willys F. Mueller, Jr., MD X X X

AppaRao Mukkamala, MD X X X

W. Archibald Piper, MD - - -

Jagdish K. Shah, MD - - X

Frederick W. Sherrin, MD X - X

Lewis E. Simoni, MD - X -

John W. Tauscher, MD X - X

Allen F. Turcke, MD X X -

Siavosh Varjavandi, MD - X -

Virgilio G. Villarreal, MD X X X

GOGEBIC:

James M. Franck, MD - - -

GRAND TRAVERSE-LEELANAU-BENZIE

Lawrence S. Loesel, MD - X X

David B. Martin, MD X X X

Kenneth H. Musson, MD - X X

Edward J. Rutkowski, MD - X -

GRATIOT:

Ashok R. Sonnad, MD - - -

HILLSDALE:

William G. Keating, MD - - -

HOUGHTON-BARAGA-KEWEENAW:

Kenneth E. Rowe, MD X X X

HURON:

Edward E. Steinhardt, MD - - -

INGHAM:

Rolland E. Bethards, MD - - -

Clyde R. Flory, MD - X X

D. Bonta Hiscoe, MD X X X

Robert A. Holmes, MD X X X

Omero S. Iung, MD - - -

David K. Johnson, MD - - -

Martin F. Jones, MD - - -

Marsha Milburn, MD X X X

Mitchell A. Rinek, MD X X X

Dean G. Sienko, MD - - X

Dawn E. Springer, MD X X X

IONIA-MONTCALM:

Doyle E. Calley, MD - X X

Louis E. Sonford, MD - - -

IOSCO-ARENAC:

Devendra K. Sharma, MD X - X

ISABELLA-CLARE:

Not Represented

JACKSON:

Jack D. Gift, MD X X X

Lorenz P. Kielhorn, MD - - -

Bruce F. Knoll, MD X X X

KALAMAZOO:

Owen M. Berow, MD X X X

M. Joseph Bowler, MD X X X

Thomas M. George, MD X X X

James B. Kilway, MD X X -

Joseph E. Kincaid, MD X X X

William J. Kube, MD X X X

Gary D. Maynard, MD X X X

David A. Milko, MD X X X

Donna L. Ritter, MD X X X

W. Mark Todd, MD - - -

Geoffrey A. Wardwell, MD X - X

Janice L. Werbinski, MD X X X

KENT:

John H. Beernink, MD - -

R. Paul Clodfelder, MDX X X

Douglas A. Edema, MD - - -

Paul O. Farr, MD X X X

Domemio R. Federico, MD X X X

Mark W. Hinshaw, MD - - -

Robert H. Hydrick, MD - X X

James R. Irwin, MD X X X

John M. MacKeigan, MD X X X

Ann M. Minnema, MD X X X

Ralph W. Ortwig, MD - - X

John P. Papp, MD X X X

Brian V. Phillips, MD X X -

Sarla Puri, MD - - -

John C. Rienstra, MD - - -

Jack L. Romence, MD X X X

David L. Sharp, MD X X X

Peter D. Van Vliet, MD X X X

James K. Watkins, MD X X X

LAPEER:

William G. Tucker, MD X - -

LENAWEE:

Inad Haddad, MD X X X

LIVINGSTON:

Thomas F. Higby, MD - - -

LUCE:

Elisa C. Geronaga, MD - - -

MACOMB:

James B. Anderson, MD - - -

Arsenio V. DeLeon, Jr., MD - X X

Ben R. Fajardo, MD - - -

Paul R. Grandolph, MD X - X

Joel M. Kriegel, MD - - -

Samir M. Ragheb, MD X - X

Richard A. Stone, MD - - -

Kenneth Weinberger, MD - - X

MANISTEE:

Vickers C. Hansen, MD X X -

MARQUETTE-ALGER:

Busharat Ahmad, MD X X X

Randall M. Johnson, MD X X X

MASON:

Timothy R. Woltanski, MD - - -

MECOSTA-OSCEOLA-LAKE:

Darrel J. Potter, MD - - -

MENOMINEE:

Harold P. Crissinger, MD - - -

MIDLAND:

Roy M. Goethe, MD - - -

Gary S. Smith, MD X X X

Robert L. Snyder, MD - - -

MONROE:

David J. Lieberman, MD X X X

Amir H. Mehregan, MD - - -

MUSKEGON:

Stephen E. Fisher, MD - - -

Dock L. Kamps, MD - - -

Rodney L. Mirich, MD - - -

Robert C. Packer, MD X X X

A. James Potter, MD - - X

NEWAYGO:

James D. Webb, MD X X X

NORTH CENTRAL:

Warren E. Bontrager, MD X X X

NORTHERN MICHIGAN:

Reed K. Freidinger, MD X X X

Dennis M. Joy, MD X X X

Richard Wakulat, MD X X X

OAKLAND:

Jaime V. Aragones, MD X X -

Joseph A. Arena, Jr., MD - X X

Edward E. Barton, MD - - -

Steven S. Bolton, MD X X X

Arnold L. Brown, MD X X X

Hari G. Chopra, MD - - -

Harry L. Doerr, MD - - X

Nitin C. Doshi, MD - - -

Edward E. Elder, Jr., MD X X X

Continued on following page

Continued from page 69

George R. Gerber, MD	X	X	-
Kenneth W. Gitlin, MD	X	-	X
Harvey W. Halberstadt, MD	X	-	-
Shamsul M. Haque, MD	-	-	-
Seymour Krevsky, MD	X	-	-
Kamalesh Lahiri, MD	-	-	-
Bruce T. Lessien, MD	X	-	-
Robert S. Levine, MD	-	-	X
Thomas K. Mathew, MD	X	X	-
Alan M. Mindlin, MD	X	X	X
Moufid Mitri, MD	X	-	X
Peter T. Muller, MD	X	-	-
Steven E. Newman	X	X	X
Panayotis C. Pesaros, MD	X	X	X
Renato, G. Ramos, MD	X	X	-
James A. Read, MD	X	-	X
Joseph L. Schirle, Jr., MD	X	-	-
Armen Shekerjian, MD	X	-	X
Marvin L. Starman, MD	-	-	-
Sherry L. Viola, MD	-	-	-
Gertraud Wollschlaeger, MD	X	X	X
OCEANA:			
V. Dale Barker, MD	-	-	-
ONTONAGON:			
James P Strong, MD	-	-	-
OTTAWA:			
William D. Doebler, MD	X	X	X
Arnold R. Dood, MD	-	-	-
Michael Driscoll, MD	X	X	X
M. Gary Robertson, MD	-	-	-
William VanderVliet, MD	X	X	X
SAGINAW:			
Edgar P. Balcueva, MD	X	X	X
Leroy C. Barry, MD	X	X	X
Thomas A. Egleston, MD	-	X	-
Richard C. Hausler, MD	X	X	X
Richard P. Heuschele, MD	X	-	X
Ronald L. Jenson, MD	-	-	-
Robert A Margulies, MD	X	X	X
Charles E. Mueller, MD	X	X	X
Jacob, C. Ninan, MD	X	X	X
ST. CLAIR:			
Timothy B. Aiken, MD	X	X	X
Ronaldo S. Balboa, MD	-	-	-
John C. Sullivan, MD	-	-	-
ST. JOSEPH:			
Lawrence R. Werschky, MD	-	-	X
SANILAC:			
Duane E. Smith, MD	-	-	-
SCHOOLCRAFT:			
Duane L. Waters, MD	-	-	-
SHIAWASSEE:			
Timothy D. Oliver, MD	X	-	-
TUSCOLA:			
Alfonso C. Ferreira, MD	X	X	-
VAN BUREN:			
Michael J. Parks, MD	X	X	X
WASHTENAW:			
Tama D. Abel, MD	X	X	X
Allen C.D. Brown, MD	-	-	-
Robert H. Burke, MD	-	-	-
Karl J. Edelmann, MD	X	X	X
C. Peter Fischer, MD	-	-	-
Carl M. Frye, MD	-	-	-
Manfred Marcus, MD	-	X	X

Raymond C. Noellert, MD	X	X	X
Rhoda M. Powsner, MD	-	X	X
Terry E. Ragland, MD	-	X	X
Diana M. Rothman, MD	-	-	-
Douglas B. Siders, MD	-	-	-
Michael W. Smith, MD	-	X	X
L. Paul Sonda, MD	-	-	-
Carl Van Appledorn, MD	-	-	X
Scott W. Woods, MD	X	X	X
WAYNE:			
Elie D. Aboulafia, MD	-	-	-
Susan E. Adelman, MD	X	X	X
Robert D. Allaben, MD	X	X	X
Hassan Amirikia, MD	X	X	-
Lourdes V. Andaya, MD	-	-	-
Firooz Banooni, MD	X	-	X
Edmund M. Barbour, MD	-	-	-
Joseph M. Beals, MD	X	X	X
Joseph J. Berke, MD	X	-	X
John G. Bielawski, MD	X	-	-
David H. Blinkhorn	-	-	-
Arthur M. Clark, MD	-	X	-
Martin H. Daitch, MD	X	X	X
L. Devireddy, MD	-	-	-
Chandra M. Edwin, MD	-	-	-
Angel Farina, MD	X	X	X
John F. Fennessey, MD	X	X	X
Frederick W. Fitzpatrick, MD	X	X	-
James P. Gallagher, MD	-	X	X
Vincent, J. Gallant, MD	-	-	-
Magdy M. Hanna, MD	-	-	-
Reginald W. Harnett, MD	-	-	-
William A. Harrity, MD	-	X	-
Gerhardt A. Hein, MD	-	-	-
H. Richard Henderson, MD	X	X	X
George C. Hill, MD	X	X	X
Samuel D. Indenbaum, MD	-	X	X
Ashok B. Jain, MD	-	-	-
Cecil R. Jonas, MD	-	-	-
James E. Kackley, MD	-	X	-
Dorothy Kahkonen, MD	X	X	X
George M. Kazzi, MD	-	-	-
Mark D. Kolins, MD	-	-	-
Nicholas J. Lekas, MD	-	-	-
Stanley H. Levy, MD	-	-	-
Robert P. Lilly, MD	-	-	-
Floyd H. Lippa, MD	-	-	-
Gerald H. Mandell, MD	X	X	X
Robert E. McKnight, MD	-	X	X
Richard Mencer, MD	-	X	X
Paul G. Mitchell, MD	X	X	X
Gale S. Northcross, MD	-	-	-
Kevin M. O'Brien, MD	-	-	-
Steven E. Olchowski, MD	X	X	X
Joseph R. Oldford, MD	-	-	-
Harold Perry, MD	X	X	-
Russel F. Proud, MD	X	X	X
Foster K. Redding, MD	X	X	X
Daniel J. Reddy, MD	X	X	X
Jan Rival, MD	-	-	-
Jack Ryan, MD	-	-	-
Rojan Samudrala, MD	-	X	-
Ivan C. Schatten, MD	-	X	X
Fred R. Severyn, MD	X	-	-
Jack Shapiro, MD	X	-	-
S.K. Singal, MD	-	-	-
Orlando S. Sison, MD	-	X	-
Robert A. Songe, MD	-	-	-
Dorai K. Sukumaran, MD	-	-	-

James M. Switzer, MD	-	-	-
Arthur A. Ulmer, MD	X	X	X
Jay Victor, MD	X	X	-
William Webb, MD	X	X	X
Joseph J. Weiss, MD	-	-	X
Fred W. Whitehouse, MD	-	-	X
William A. Willoughby, MD	-	-	-
Bernard J. Woodley, MD	X	X	-
Louis R. Zako, MD	X	X	X

WEXFORD-MISSAUKEE

Dennis E. Van Alst, MD	X	X	X
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MEMBERS-AT-LARGE

IMMEDIATE PAST PRESIDENT:

Susan Hershberg Adelman, MD	X	X	X
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MEDICAL SCHOOL DEANS:

University of Michigan:			
Wayne State University:			
Robert J. Sokol, MD	-	-	-
Michigan State University:			

MEDICAL STUDENT SECTION:

University of Michigan:

Michigan State University:

Niketa Davi	X	X	-
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Wayne State University:

Scott Gibson	X	X	X
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HOSPITAL MEDICAL STAFF SECTION:

John A. Rupke, MD	X	X	X
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YOUNG PHYSICIANS SECTION:

Patrick J. Droste, MD	-	X	-
Douglas L. Colberg, MD	-	-	X

RESIDENT PHYSICIAN SECTION:

Michael D. Chafy, MD	X	X	X
Atul Shab, MD	X	-	-

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Allen C.D. Brown, MD	X	X	-
Timothy B. Aiken, MD	-	-	X

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MI ALLERGY SOCIETY:

James H. Saker, MD	-	-	-
Clyde R. Flory, MD	-	X	-

MI SOCIETY OF ANESTHESIOLOGISTS:

David M. Krhovsky, MD	X	X	-
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MI CHAPTER-AMERICAN COLLEGE OF CHEST PHYSICIANS:

Robert E. Klimek, MD	-	-	-
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MI SOCIETY OF COLON & RECTAL SURGERY:

Martin A. Luchtefeld, MD	-	-	-
Eric J. Szilag, MD	-	-	X

MI DERMATOLOGICAL SOCIETY:

Barbara M. Mathes, MD	X	X	X
-----------------------	---	---	---

MI CHAPTER-AMERICAN COLLEGE OF EMERGENCY PHYSICIANS:

Harvey J. DeMaagd, MD	X	-	-
-----------------------	---	---	---

MI ACADEMY OF FAMILY PHYSICIANS:

Manuel A. Echandi, MD	X	-	X
-----------------------	---	---	---

MI SOCIETY OF GASTROINTESTINAL ENDOSCOPY:

Michael C. Duffy, MD	-	-	-
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MI SOCIETY OF GENERAL SURGEONS:

Donald C.Camp, MD	X	-	X
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MI HEALTH OFFICERS ASSOCIATION:

Not Represented

MI SOCIETY OF INFECTIOUS DISEASE:

Tom Madhanan, MD X X X

MI SOCIETY OF INTERNAL MEDICINE:

Vernon E. Wendt, MD - - -

Catherine A. Upton, MD - - X

MI ASSOCIATION OF NEUROLOGICAL SURGEONS:

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Alexa Canady, MD - - X

MI NEUROLOGICAL ASSOCIATION:

Not Represented

MI COLLEGE OF NUCLEAR PHYSICIANS:

Not Represented

MI SECTION-AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY:

James G. Kornmesser, MD - - -

Domenic R. Federico, MD X X X

MI OCCUPATIONAL MEDICAL ASSOC.:

Not Represented

MI OPHTHALMOLOGICAL SOCIETY:

Paul P. Fecko, MD - - -

MI ORTHOPAEDIC SOCIETY:

Kenneth S. Merriman, MD X X X

MI OTO-LARYNGOLOGICAL SOCIETY:

Not Represented

MI SOCIETY OF PATHOLOGISTS:

Edwin M. Knights, Jr., MD - - -

MI CHAPTER-AMERICAN ACADEMY OF PEDIATRICS:

Irving M. Miller, MD - - -

MI SECTION OF CLINICAL**PHARMACOLOGY & THERAPEUTICS:**

Not Represented

MI CHAPTER-AMERICAN COLLEGE OF PHYSICIANS:

John P. Papp, MD X X X

MI ACADEMY OF PHYSICAL MEDICINE & REHABILITATION:

Sherry L. Viola, MD - - -

MI ACADEMY OF PLASTIC SURGEONS:

Michael J. Schenden, MD - - -

John Beernink, MD X - -

MI PSYCHIATRIC SOCIETY:

Not Represented

MI PSYCHOANALYTIC SOCIETY:

Mayer Subrin, MD - - -

MI RADIOLOGICAL SOCIETY:

Phillip E. Perkins, MD X - -

MI CHAPTER-AMERICAN COLLEGE OF SURGEONS:

Robert D. Allaben, MD X X X

MI SOCIETY OF THERAPEUTIC RADIOLOGISTS:

Not Represented

MI SOCIETY OF THORACIC AND CARDIOVASCULAR SURGEONS:

Allen Silbergleit, MD X - -

MI THORACIC SOCIETY:

Robert E. Klimek, MD - - -

MI UROLOGY SOCIETY:

Farid Jano, MD - - -

PHYSICIAN OPPORTUNITY

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The Association provides a complete range of specialty care units, including adult and pediatric intensive care, coronary care and emergency care. We recently opened The Family Birth Center™ – a progressive, new, single-room obstetrics unit. And we cooperate in an active residency program

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St. Luke's Healthcare Association is a diverse and growing organization, anxious to meet with physicians interested in pursuing a career marked by a strong administration/physician working relationship and a team approach to patient care.



If you're such a physician, St. Luke's Healthcare Association and Saginaw, Michigan, are natural selections. Contact us today for additional information.

Call or write Jan Gould,
Physician Recruiter:

St. Luke's Hospital
700 Cooper Ave.
Saginaw, MI 48602
1-800-633-3546.

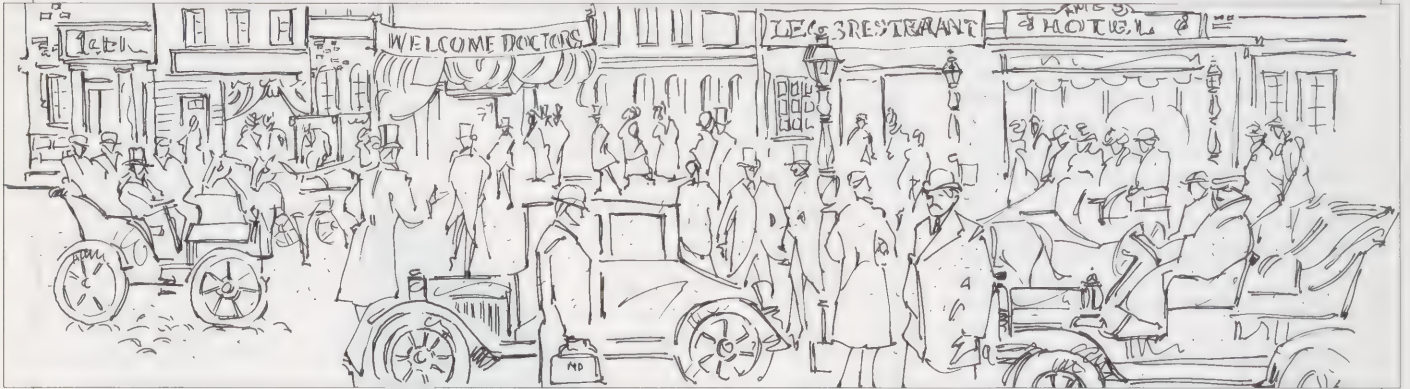


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A LOOK BACK IN TIME

MSMS House of Delegates - 1892 Meeting

BY HERB AUER



If a machine carried a present-day physician back in time 100 years to the 1892 MSMS Annual Meeting, the scenario would look something like this: the physician would be staying in a guest home because hotels were inadequate; the physician would be asked to make a cash contribution to build up the MSMS treasury, which was then only \$1,150; and a key interest of the physician's would have been to get Michigan congressmen to work for the appointment of a physician to direct the national medical bureau.

Yes, in many ways the 1892 Annual Meeting, held in Flint, was different than the recent 1992 MSMS House of Delegates Meeting. But there are many similarities. At both meetings, the MSMS members heard an address by the MSMS president, elected new officers and paid tribute to physicians who had died during the past year.

Much is known about the meeting 100 years ago because, at that time, MSMS was printing a complete bound book called, "Annual Meeting Transactions" for all members. The 1892 edition of 464 pages contained all the business of the meeting as well as scientific papers presented by 37 Michigan physicians.

The 1892 meeting was hosted by the 21 physicians in Genesee County. (There were

only 14 then in nearby Ingham County). The MSMS election process 100 years ago was different. There was a Nominating Committee which presented a slate for first-vice president, second-, third- and fourth-, as well as general secretary, treasurer and members of the Judicial Council.

The *Transactions*, in part, reports that "Doctor C.J. Lundy, of Detroit, was nominated for the office of president and he was elected unopposed." In his acceptance speech, he pledged that "he would do his work, but raising the standard of the medical profession depends upon the work of the rank and file." He recalled his service as president of the Detroit Medical and Library Association.

The MSMS House of Delegates meeting now deals with many issues facing physicians and medicine. An important resolution on May 5, 1892, was "to notify the Michigan representatives in Washington that it is the wish of the medical profession in Michigan that a cabinet officer be appointed as the head of the medical bureau."

Physicians became members of MSMS through a different procedure in 1892. The Judicial Council recommended that 45 physicians be elected to full membership. The Council also reported that a physician from

Monroe County had been expelled from membership "for conduct unbecoming a member of this Society in circulating a highly sensational circular setting forth the marvelous efficiency of proprietary and secret remedies of his own manufacture."

The meeting also approved a recommendation that 44 delinquent members be dropped.

The treasurer reported the balance a year before was \$64.18 and the new balance was \$1,164.18. A suggested special voluntary contribution to increase the MSMS treasury resulted in \$595.50 cash and \$62 in pledges.

Some early plans were made for the AMA annual convention that was to be held later that year in Detroit.

The 1892 *Transactions* opened with the address of the 1891-92 president, George E. Ranney, MD, of Lansing. His address was entitled "Death - A Universal Law." He recounted the "wonderful strides in progressive medicine" but recognized "we are foiled and stand in the presence and silence of death, utterly vanquished, gazing upon the wreck the victor has left." Doctor Ranney closed praising the work of physicians of the world: "No vocation or calling or pursuit contributes so much to alleviate the distress and suffering of our race as the time-honored profession of which we are members."

Among the presenters of scholarly papers in 1892 were five members who later became state society presidents. Donald MacLean, MD, of Detroit, who gave a "Report of Surgical Cases," was president in 1884; Victor C. Vaughan, MD, of Ann Arbor, who discussed "The Infection of Food," was president in 1896; J.H. Carstens, MD, of Detroit, "The Year's Work in Laparotomy," was president in 1909, and Reuben Peterson, MD, of Grand Rapids, "Review of 25 Consecutive Cases of Abdominal Section," was president in 1914.

The two-day annual meeting was packed full and the delegates voted to consider three-day meetings in the future.

It was announced that the 1893 annual meeting would be in Muskegon, the second week in May.

The *Transactions* carried a protective disclaimer on page three under the list of the five members of the Publication's Committee:

"The Society does not hold itself responsible for the views enunciated in the papers read at its meeting."

The 1892 MSMS membership was printed in the *Transactions* and MSMS then had 538 active members. The 10 counties with the most members were Wayne 108, Kent 52, Saginaw 35, Washtenaw 27, Oakland 21, Genesee 21, Kalamazoo 19, Calhoun 18, Shiawassee 15 and Ingham 14. Today, there are changes in the 10 largest component societies: Wayne 1730, Oakland 945, Kent 628, Washtenaw 482, Kalamazoo 381, Genesee 349, Ingham 308, Macomb 278, Saginaw 235, Grand Traverse 138. Note: Shiawassee, in the top 10 in 1892, now has 27 members in 1992.

The news of the election by the MSMS members on May 6, 1892, of Charles J. Lundy, MD, as the new president probably had not reached all the MSMS members when Doctor Lundy died on May 24.

Soon after returning to Detroit from the 1892 Annual Meeting, he suffered a painful reoccurrence of an abscess related to an appendicitis problem. Three surgeons decided "an operation was inevitable. It was performed the next morning and, at first, it seemed Doctor Lundy would rally." However, he died at 5 am the next day.

As a young man, Doctor Lundy taught at a Detroit business college and then received his AM degree from Notre Dame. He taught there and became interested in medicine. He enrolled at the Rush Medical College which was destroyed in the Great Chicago Fire. He was graduated in 1872 from the University of Michigan and began practice in Detroit in 1875. He was one of the founders of the Michigan College of Medicine and was professor of the diseases of the eye, ear and throat and he remained when MCM consolidated with the Detroit College of Medicine.

G.V. Chamberlain, MD, of Flint, elected the same day as Doctor Lundy, advanced from the office of first vice-president to succeed Doctor Lundy as the 28th president of MSMS.

And so goes the history of the 1892 meeting. ■

Herb Auer was deputy director of MSMS before becoming executive director of the Michigan Health Council in 1979.

Michigan delegates act on a variety of AMA House of Delegates issues

BY CLAUDIA SKUTAR



Members of Michigan's Delegation to the AMA participate in proceedings of the AMA House of Delegates.

In late June, 22 Michigan physicians packed their bags and headed to Chicago for five days of intense study and debate at the AMA House of Delegates. They joined 413 colleagues from around the country to negotiate policy on complex medical issues physicians must face each day.

Those issues are so numerous that it took a notebook four inches thick and weighing more than 10 pounds to contain the resolutions and reports outlining them. Every physician at the meeting carried one.

The 22-member Michigan Delegation to the AMA was no exception. In fact, to help its members bone up on the more than 300 resolutions and 100 reports, the largest AMA House of Delegates agenda in its history, the delegation caucused at 6:30 a.m. every morning to review the AMA House of Delegates handbook. Delegation Chairman Billy Ben Baumann, MD, Pontiac, and Vice Chairman Robert D. Allaben, MD, Detroit, assigned teams of Michigan delegates to track specific committees. They then updated their colleagues each morning on the resolutions assigned to those committees.

The dozen Michigan resolutions which the delegation took to the annual meeting fared well under AMA House actions. Two were referred to the AMA Board of Trustees for further study, and the rest were adopted in some form.

See article on page 76 for details..

Michigan physicians also made a strong showing at the meeting. In addition to members of the Michigan Delegation, other AMA delegates from Michigan attended the annual meeting. These included Tama D. Abel, MD, Ann Arbor, of the AMA Young Physicians Section; Ronald M. Davis, MD, Lansing, chief medical officer of the Michigan Department of Public Health, and a Michigan delegate from the American College of Preventive Medicine; Raymond A. Gagliardi, MD, Pontiac, of the American College of Nuclear Medicine; and William M. Wardell, MD, Ann Arbor, of the American Society for Clinical Pharmacology and Therapeutics. Kamran S. Moghissi, MD, Detroit, a member of the American Fertility Society, also joined the Michigan contingent this year because the AMA in June granted that society representation at the House of Delegates.

Two Michigan physicians were elected to AMA posts (see accompanying story on AMA elections). AMA Board of Trustees incumbent Frank B. Walker, MD, St. Clair Shores, was reelected to a one-year term. Former MSMS President Susan H. Adelman, MD, Southfield, was elected to a three-year term on the AMA Council on Medical Service, which handles health care delivery issues.

Doctor Abel, former chairman of the Michigan Young Physicians Section, was appointed to a two-year term on the AMA Women's Advisory Council. Just prior to the annual meeting, newly-elected MSMS Board member Rhoda M. Powsner, MD, Ann Arbor, and MSMS member Elissa P. Benedek, MD, Ann Arbor, both were appointed to the AMA National Advisory Council on Domestic Violence and Abuse.

MSMS President Thomas C. Payne, MD, East Lansing, spent time during the meeting gathering information on how to make physicians more aware of family violence and what they can do to help victims of it. A theme of Doctor Payne's presidency is physician education on this widespread public health dilemma. While at the AMA annual meeting, Doctor Payne met with AMA staff members to learn more about the AMA's program on family violence; attended a joint forum on the topic presented by the Resident Physicians Section and Medical Student Section; and taped a television interview for Michigan audiences.

The AMA Membership Outreach Campaign also honored Michigan physicians for outstanding efforts in recruiting new members. MSMS award recipients included Doctor Abel; Busharat Ahmad, MD, Marquette; Hassan Amirikia, MD, Detroit; Gilbert B. Bluhm, MD, Troy; Brooks F. Bock, MD, Detroit; Peter A. Duhamel, MD, Rochester; Krishna K. Sawhney, MD, Farmington Hills; Narinder K. Sherma, MD, Farmington Hills; and Louis R. Zako, MD, Dearborn Heights.

Claudia Skutar is a communications specialist for MSMS.



Michigan AMA Delegation Chairman Billy Ben Baumann, MD, Pontiac, (at podium) leads a morning meeting of the delegation. The group caucused daily to review AMA House of Delegates business prior to each session of the House.

AMA special sections meet preceding House of Delegates

Four AMA special sections held their annual meetings in Chicago just prior to the AMA House of Delegates. The AMA Hospital Medical Staff Section, Medical Student Section, Resident Physicians Section and Young Physicians Section elected officers and passed resolutions. Following is a brief summary of their activities.

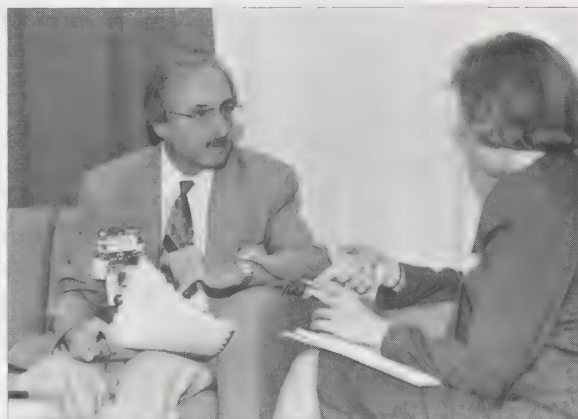
Hospital Medical Staff Section

The AMA Hospital Medical Staff Section took action on 54 resolutions and 24 reports ranging in topic from medical waste disposal to

credentialing to the National Practitioner Data Bank.

Highlights of the section's business included unanimous passage of a resolution on organized medicine's role in health care. The resolution was sent to the House of Delegates, where considerable debate on the issue was heard. That HMSS resolution was combined by the AMA House of Delegates with several similar resolutions and passed. The substitute resolution, in part, stated that, to maintain the physician's role as patient advocate, "there should be appropriate legislative, regulatory and judicial action providing for formal physician organization involvement" in health

Continued on following page



MSMS President Thomas C. Payne, MD, East Lansing, (left) meets with an AMA staff member to discuss his efforts to educate Michigan physicians on what they can do about family violence. Doctor Payne also learned more about what the AMA is doing at a national level to educate physicians on the topic.

Continued from page 75

care policy development and implementation."

MSMS member Peter A. Duhamel, MD, Rochester, vice chairman of the section, assisted in conducting the business of its 19th assembly. Harry L. Doerr, MD, Southfield, chaired Reference Committee C, while Donald C. Camp, MD, Niles, served as a member of Reference Committee A.

Medical Student Section

The section considered 28 resolutions and 12 reports, with debate centering on AMA policy regarding HIV-infected medical students. In conjunction with the AMA Resident Physicians Section, the medical students cosponsored a panel presentation on treating family violence. Medical Student Section attendees participated in breakout sessions on what they can do about the problem and how to approach patients.

Resident Physicians Section

Michigan Delegation member Fernando C. Gomez, MD, Royal Oak, represented Michigan residents at the annual Resident Physicians Section meeting. The group considered 23 resolutions on areas such as psychotherapy for medical students and residents; HIV insurance for medical students and residents; Medicare new physician reimbursement; and right to bankruptcy.

Michigan delegate Eric M. Rudnick, MD, Lansing, received an AMA/Burroughs Wellcome Company Leadership Program grant. The program enables residents interested in organized medicine to attend both the AMA interim and annual meetings.

Young Physicians Section

Doctor Abel was elected as an AMA alternate delegate from the AMA Young Physicians Section Governing Council. She also served on the section's credentialing committee at this year's meeting.

The section reviewed 27 resolutions and eight reports. AMA YPS members also took time to hear a presentation on restoring equity in



MSMS President-Elect Gilbert B. Bluhm, MD, Troy, (right) is pictured here with AMA House of Delegates Vice Speaker Richard F. Corlin, MD, (left) and AMA Immediate Past President James S. Todd, MD. Doctor Bluhm, along with seven other MSMS members, received an AMA Membership Outreach Campaign award honoring out-standing physician efforts in recruiting new members.

Medicare payments to new physicians. Breakout sessions on political action and media training helped the section to educate members on what they can do to work toward restoring that payment equity.

AMA Auxiliary changes name

Changing times and the need to reflect its diverse constituency led the AMA Auxiliary this June to change its name of seven decades. Delegates to the group's annual meeting, conducted simultaneously with the AMA House of Delegates annual June meeting, approved the change by a large margin of 229 votes to 88 votes. The group's new name is the AMA Alliance, with the tagline, "Physicians' spouses dedicated to the health of America."

AMA Alliance President Sherry S. Strebel cited one reason for the change in a Board of Directors report reviewed by delegates. Strebel wrote the change was recommended to help the organization "with the challenge of moving with the times in new directions that broaden the base of membership and involvement, as well as effectiveness in programming."

Alliance delegates took up other business during their meeting, considering 30 resolutions and three reports. Resolution topics included food eating disorders, substance abuse during pregnancy, childhood immunizations, family violence, and gender disparity in clinical research. The Alliance adopted membership development as its theme for 1992-1993.

How Michigan resolutions fared at the AMA House of Delegates

Of the 12 resolutions carried to the AMA House of Delegates by the Michigan Delegation, two were referred to the AMA Board of Trustees for further study. The rest were adopted in one form or another. Here is a summary of what happened to each resolution:

#241—Medicaid Sterilization Consent Requirement—This resolution was referred to the Board for further study. It calls on the AMA to work toward revision of federal Medicaid policy. Currently that policy requires physicians to complete a form obtaining informed consent prior to performing a hysterectomy or other sterilization.

#242—Advance Payments During Medicare Slowdowns—Adopted in substitute form, this resolution asks



Harry L. Doerr, MD, Southfield, an MSMS member and delegate to the AMA Hospital Medical Staff Section, addresses the June assembly of that group. Doctor Doerr chaired Reference Committee C during the section's annual meeting just prior to the AMA House of Delegates.

the AMA to seek legislation requiring the Health Care Financing Administration to make interim payments to physicians. This would help when delays in Medicare claims processing result in slow payment.

#308—Reduction in Cost of Medical School Education—Under this resolution, adopted with amendments, the AMA will work with all appropriate groups to study ways to reduce medical education costs to students.

#422—Number of Sex-Related Scenes on Television—This resolution, formerly #534, requires the AMA to develop a program to reduce the number of sex-related scenes on television during family viewing hours. It was adopted.

#535—Support for Barrier-Free Immunizations for Children—This resolution was combined into a substitute with similar legislation on the same topic, and then adopted. It calls on the AMA to encourage the Centers for Disease Control to simplify required immunization information pamphlets.

#536—Medical Waste Disposal Costs—This resolution was incorpo-

rated into a substitute and adopted. The substitute calls on the AMA to work with appropriate groups toward a more rational definition of contaminated medical waste and a more rational disposal policy.

#714—HCFA Care Guidelines Publication for All Physicians—A report calling on the AMA to work with health care groups on joint principles for disclosure of review and coverage criteria was adopted in lieu of this resolution.

#717—HCFA Scheduling of Patient Dumping Complaint Investigations—This was referred to the Board for further study. The resolution points out HCFA's failure to verify patient or hospital complaints on patient dumping, and the lack of notice physicians receive when HCFA does investigate. It also calls on the AMA to seek stricter HCFA standards by 1) HCFA requiring corroborating information before an investigation; 2) HCFA providing advance notice of a survey; and 3) HCFA providing an appeal of findings.

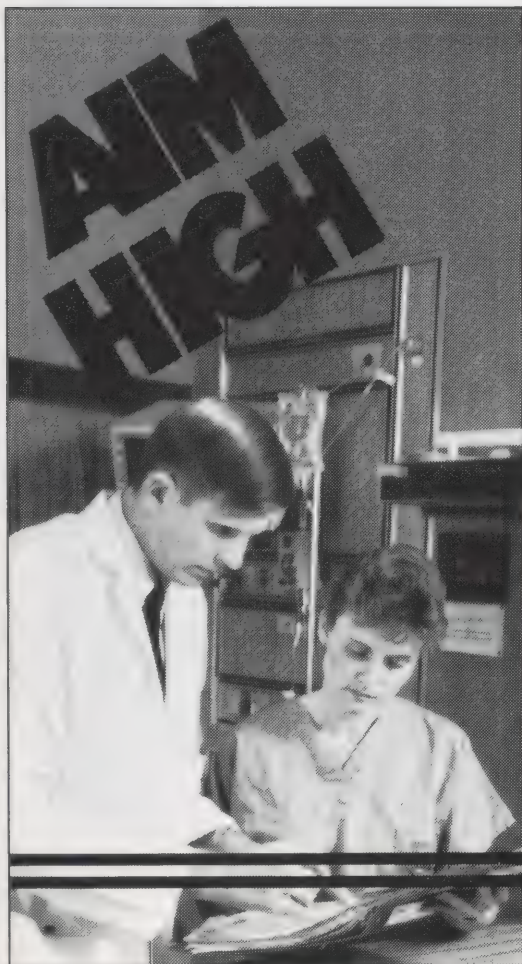
#813—Uniform Current Procedural Terminology (CPT) Coding—

This was adopted in substitute form. The substitute calls on the AMA both to support use of CPT coding by all third-party payers, and to urge payers to update them annually.

#814—Audit System for the New Current Procedural Terminology (CPT) Codes in Physicians' Offices—Under the substitute form this resolution was adopted in, the AMA is required to further develop guidelines that would aid physicians in assessing their own medical records and making coding decisions.

#815—Limit on Reportable Settlements: National Practitioner Data Bank—A report calling on the AMA to review the entire National Practitioner Data Bank was adopted in lieu of this resolution. The original Michigan resolution would have placed a \$30,000 ceiling on settlement amounts required to be reported to the Data Bank.

A memorial resolution honoring the late George Slagle, MD, Battle Creek, also was adopted by the AMA House of Delegates. Doctor Slagle served as AMA vice president during 1975-1976. ■



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Successful MSMS candidates increase Michigan's AMA representation

BY CLAUDIA SKUTAR



Billy Ben Baumann, MD, Pontiac, chairs the 22-member Michigan Delegation to the AMA, which was instrumental in aiding the elections of Doctor Adelman and Doctor Walker to AMA office.



AMA Board of Trustees incumbent Doctor Walker was reelected at the June meeting. During previous terms, Doctor Walker gained the respect of his Board colleagues through his work on planning, finance and membership issues.

Organized medicine doesn't readily conjure up images of policy-making or the political process. Yet, the AMA functions as a kind of physician's mini-Congress.

Year-round its councils, committees, task forces and commissions work to study information and gather current medical opinion on a wide array of complex issues physicians are faced with daily. This information is used to set medical policy that influences many beyond the nation's physicians. Twice annually physician representatives meet as the AMA House of Delegates to further distill that policy.

Effects of the work done by the AMA's component bodies are far-reaching, making the role they play in medical policy-making an important one. It's at this point that an individual physician, representing hundreds, or even thousands, of other physicians, can shape medical policy.

The strength of this individual influence makes key a physician's election or appointment to an AMA body. Once a physician determines that he's going to run for an AMA office, both the physician and his or her state delegation can spend months planning and working to win an election.

This is precisely what happened in the case of two Michigan physicians who ran successfully for office at the AMA House of Delegates annual meeting in June.

MSMS members Frank B. Walker, MD, St. Clair Shores, and Susan H. Adelman, MD, Southfield, officially began their 1992 candidacies for AMA offices with announcements last December at the AMA House of Delegates Interim Meeting. Doctor Walker sought reelection to his post on the AMA Board of Trustees, which oversees all AMA activities. Doctor Adelman sought a first-time seat on the AMA Council on Medical Service, which handles health-care delivery issues.

While both candidates actually began their campaigns about a year prior to their election, it was during the six months between official announcement and elections that their campaigns shifted into high gear.

Doctors Walker and Adelman worked hard to inform their mutual constituency, some 435 delegates to the AMA House, about their merits. Hundreds of letters were mailed. Campaign brochures were printed. Telephone contacts were

made. The foundation was being carefully laid for the four days of intense campaigning that make or break an AMA candidate. It all comes to a head on the morning during the June meeting when all AMA delegates vote their preferences.

During that same 12-month candidate preparation period, the 22-member Michigan Delegation to the AMA, led by Chairman Billy Ben Baumann, MD, Pontiac, and Vice Chairman Robert D. Allaben, MD, Detroit, also was planning its strategy to get both physicians elected.

While its main function is to represent Michigan physicians in AMA policy-formulation during the House of Delegates, the Michigan Delegation serves a political purpose, too. That purpose is to ensure Michigan representation on AMA component bodies, thereby cementing Michigan's role in the day-

to-day policy-making that takes place there. Stronger state representation ensures a stronger Michigan voice in AMA policy-making.

The delegation supports Michigan AMA candidates by acting as a sounding board for its members' aspirations, hearing out months, and even years, in advance who wants to run for what office and when. The delegation then lends its support to their efforts.

Since election to AMA office is no mean feat, delegation support is important, particularly at the annual meeting itself when many demands are made on Michigan candidates.

Both Doctor Walker and Doctor Adelman maintained a grueling schedule during the June AMA meeting. Out of bed before dawn, both physicians sat down daily to brief campaign strategy sessions over breakfast with the Michigan

Delegation and key MSMS staff led by MSMS Executive Director William E. Madigan. Then they were off to candidate interviews with various state delegations, interspersed with participation in regular House of Delegates business, an obligation they were still expected to fulfill as Michigan Delegation members.

Their days didn't end at five o'clock, however. To meet your constituents, you must go wherever they are. Evenings for AMA delegates at the June meeting consist of socializing with one another during receptions hosted by each state delegation. Michigan Delegation members took turns escorting Doctor Walker and Doctor Adelman to the receptions late into each evening to ensure the widest possible exposure for the two candidates.

The delegation's organization and support of its candidates paid off in election day dividends during the fourth day of the five-day meeting.

"The delegation has never worked better together politically than it did at this meeting," observed Doctor Baumann. The delegation solicited its members' help in electing its candidates, and got it."

Incumbent AMA Board of Trustees member Doctor Walker had six opponents for one of four three-year slots on the Board. While unsuccessful in gaining that three-year term on the first ballot, two more runoff ballots yielded him a one-year unexpired term. That vacancy was created by the June election of Joseph T. Painter, MD, as AMA president-elect.

Doctor Adelman competed against four other candidates to win one of two three-year slots open on the AMA Council on Medical Service. Her win came on the second of two ballots.

Voting tallies were close in both elections, said Doctor Baumann.

Continued on following page



Doctor Adelman addresses one of the many delegate coalitions which interviewed candidates for AMA office during the annual meeting.



Doctor Walker (left) and Doctor Adelman (right) made their acceptance remarks to the full AMA House of Delegates following announcement of their elections to AMA offices.

Continued from page 79

However, Michigan's candidates won because of "their intrinsic strengths."

"Doctor Walker and Doctor Adelman both campaigned very hard," said Doctor Baumann. "I think AMA delegates saw their strong points, and remembered them when it came time to vote."

Doctor Walker campaigned on his Board experience in planning, finance and membership issues. "While they may not be glamorous, they're important," said Doctor Walker. "Without them, you can't accomplish many of the other things the AMA does."

His experience in these areas, and his stable leadership during a time when the AMA was restructuring its financial management in recent years, gained him the respect of fellow Board members. In fact, when he lost the three-year term on the first ballot, his Board col-

leagues urged him to stay in the runoff for Doctor Painter's unexpired one-year term so that he can seek reelection next year to the longer term. Doctor Walker, at this point, is planning to do just that.

Where experience clinched incumbent Doctor Walker's seat, a main campaign theme for first-term Doctor Adelman was the AMA's need to make health care reform its top priority.

"The key issue for the AMA right now is health care reform, and the timetable is triple-time," said Doctor Adelman. "The AMA needs to work as fast and as efficiently as possible to promote Health Access America."

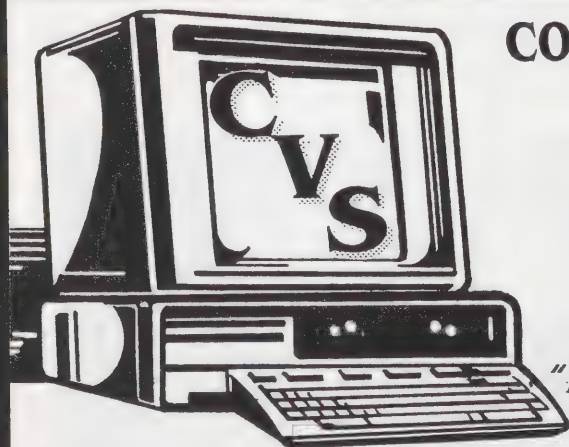
During candidate interviews with several state delegations, Doctor Adelman emphasized the critical need to make it clear to the public that access to health care is the AMA's top issue.

"I think we should maintain our

primary focus on access because that's the public's primary interest," she said. "It's a mistake to make it seem to the public that physicians' primary interest is cost."

During a brief followup election analysis for the Michigan Delegation, Doctor Adelman said she plans to draw on input from other Michigan physicians during her tenure on the Council on Medical Service. She summed up the value of her candidacy by saying that, "The more people we have on councils, the greater the opportunity to bring Michigan people and issues forward."

Doctor Walker agreed, noting that, as an AMA Board Trustee, he'll be helping to do that, particularly in bringing health care reform to the public's attention. "Health care reform is on the front burner," Doctor Walker said. "It's very important to make the public aware of what's happening." ■



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HIGHLIGHTS OF FIRST MSMS JOINT SECTION MEETING

Photos by Patrick Yockey

The MSMS Sections for Hospital Medical Staffs, Young Physicians and International Medical Graduates convened in a joint annual meeting for the first time last March. The Joint Section Meeting, held at the Dearborn Inn, offered delegates from all three sections the opportunity to mingle and share their concerns.

Portions of the meeting were held for all three sections' delegates combined, while the sections conducted their business matters separately. This allowed for more streamlined and economical planning, the sharing of staff, supplies and facilities.

Following are highlights of the Joint Section Meeting.



MSMS Speaker Robert D. Allaben, MD, (at podium), briefed delegates of all three sections on rules and order of business. Seated at the dais are (l to r): Gary D. Maynard, MD, MSMS vice speaker; Robert D. Burton, MD, then MSMS president; Tama Abel, MD, chairman, MSMS Young Physicians Section; Appa Rao Mukkamala, MD, chairman, MSMS Section for International Medical Graduates; and Krishna K. Sawhney, MD, chairman, MSMS Hospital Medical Staff Section.



Approximately 150 delegates from all three sections gathered in Dearborn for the first MSMS Joint Section Meeting. Portions of the meeting were held for all three section's delegates combined.

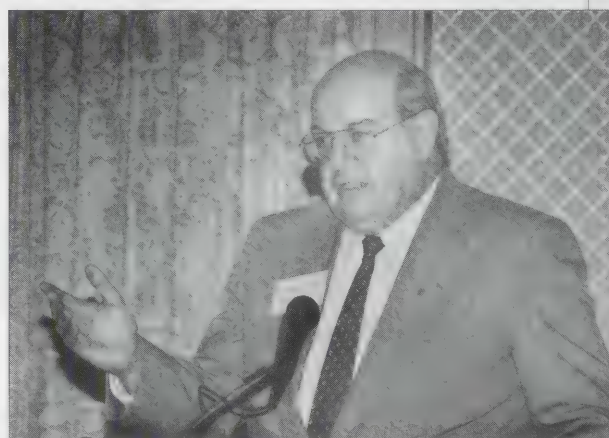
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Each section held separate meetings to conduct business and hear testimony on resolutions. The MSMS Section for International Medical Graduates heard testimony on 25 resolutions. Shown above are members of Reference Committee A who were assigned 13 resolutions concerning various IMG issues. They are (l to r): M.R. Siddiqui, MD; Jagdish Shah, MD; Rojan Samudrala, MD, chairman; and Gertraud Wollschlaeger, MD.



Leaders of organized medicine at all levels attended the Joint Section Meeting. Shown (l to r) are: Krishna K. Sawhney, MD, chairman, MSMS Hospital Medical Staff Section; Robert E. McAfee, MD, vice chairman, AMA Board of Trustees; Frank B. Walker, MD, AMA Board of Trustees; and Jack L. Barry, MD, MSMS Chairman of the Board.



Robert E. McAfee, MD, vice chairman of the AMA Board of Trustees, presented his keynote address to delegates and guests at a luncheon during the Saturday meeting.

Earlybirds were invited to attend a reception the evening before the meeting. Spouses and guests of delegates from all three sections mingled with other MSMS and AMA leaders. MSMS IMG Section Chairman AppaRao Mukkamala, MD, (second from left), and his wife (left) took a moment to chat with MSMS Immediate Past President Susan H. Adelman, MD, (right). In the background is MSMS Assistant Director Kevin A. Kelly.



MSMS IMG Section Chairman AppaRao Mukkamala, MD, led IMG delegates through 25 resolutions, 17 of which were forwarded to the MSMS House of Delegates for further action.



Karl J. Edelmann, MD, was elected to serve a two-year term as chairman of the MSMS Young Physicians Section. He replaces outgoing chairman Tama Abel, MD.



MSMS HMSS Chairman Krishna K. Sawhney, MD, led HMSS delegates through several items of business, including 24 resolutions, 17 of which were forwarded to the MSMS House of Delegates for further action.



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MEMBERS NYSE/SIPC

PRESIDENT'S PAGE

Continued from page 88

violence and what we can try to do about it. This will be part of MSMS's function as a clearinghouse for information on domestic violence.

Another activity is scheduled in conjunction with the MSMS Annual Scientific Meeting November 17, 18 and 19 at the Hyatt Regency in Dearborn. We plan to hold three half-day seminars on child abuse, spouse abuse and elder abuse. We will kick off the series with a press conference on November 16 announcing the formation of the coalition and our goals to enlist physicians in the war against abuse.

Take action now

In the meantime, I urge every physician in Michigan to join the National Coalition of Physicians Against Family Violence established by the AMA. With membership comes a small certificate that can be hung in your office or exam room pledging your support to victims of domestic violence and a larger poster for waiting rooms or other highly visible spots.

Also in the meantime, I urge you to look around your own communities to discover what, if any, resources are available to you on the local level. If none exists, maybe you can do something about it; because you can be assured there are victims of domestic violence who need help, victims who, perhaps, you yourself have treated. ■

Doctor Payne is MSMS President

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Domestic Violence - Recognition and Treatment Crucial

By Thomas C. Payne, MD

An x-ray showed a definite rib fracture on the month-old infant. Was this a case of child abuse, I wondered?

After talking at great length with the mother, a nursing student, it seemed child abuse could not be the cause. Her pediatrician agreed.

Several years later, however, the pediatrician told me the baby was brought into the hospital emergency room 18 months after the rib fracture, dead on arrival.

I never did find out what happened in the case, if a ruling was ever made on the baby's death or if anyone pursued the issue of potential child abuse.

That is not the only case that has haunted me over the years.

One day I walked into my office and found a cadre of police officers and investigators. Their attention was focused on the x-rays of an 18-month-old baby who had suffered 16 fractures over a four-week period.

It seems the baby's father, for whatever reason, enjoyed breaking the baby's joints and bones. The mother finally mustered the courage to summon the law and the father fled the country. I saw the baby several months later and, physically, he had recovered completely. But what about the deep-seated mental scarring?

Although these cases have troubled me greatly over the years, it is just recently that I feel I have the wherewithal to do something about the hundreds and thousands of other cases of abuse we physicians see, but may not recognize, every year right here in Michigan.

I have dedicated my presidency to help get the

word out to Michigan physicians about recognizing and treating child abuse, child sexual abuse, domestic abuse and elder abuse.

The efforts of MSMS will dovetail with the Herculean task already accomplished by the AMA in developing specific and detailed diagnostic and treatment guidelines on these areas of abuse. As you know, AMA is committed to this project as well, publicizing the need for greater physician accountability in recognizing and treating abuse victims and committing great resources to getting information to physicians nationwide.

Local efforts crucial

But much needs to be done on the local level, too—right down to individual physician offices in our big cities

and our small towns. Abuse is everywhere, in every social and economic stratum.

To help gather helpful Michigan-specific information, MSMS, in conjunction with the MSMS Auxiliary, will call together a coalition made up of representatives from a host of concerned groups on August 19 at MSMS Headquarters. We will discuss what information is available now, what information is needed and how we will get it to physicians. One item we want to develop quickly is a comprehensive listing of places and organizations to refer possible abuse patients to for additional needs, such as shelters, legal services, social services and support groups.

Also, watch for the September issue of *Michigan Medicine*. The cover story will be on domestic

Continued on page 87



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MICHIGAN MEDICINE

SEPTEMBER 1992
VOL. 91, NO. 9

*Award-Winning
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*Cover
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Domestic Violence

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women in medicine
• Plus a special
report on women IMGs

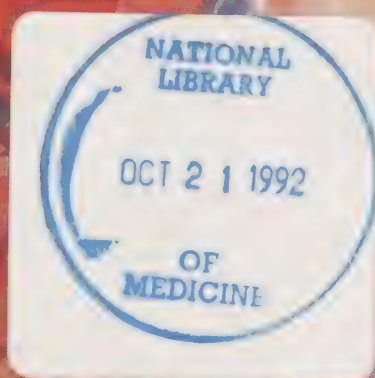
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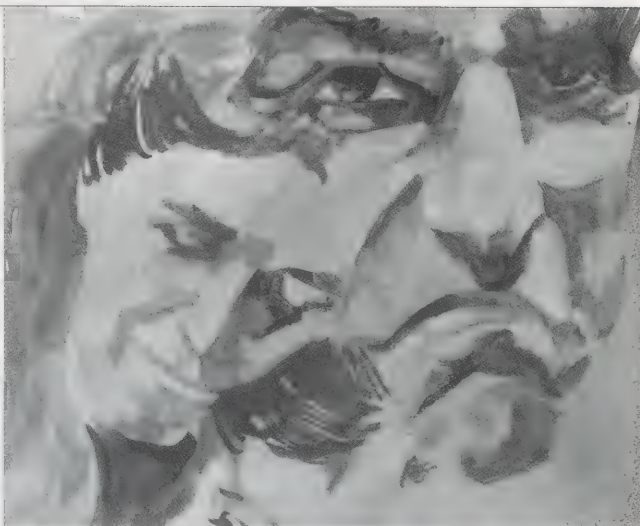
MICHIGAN MEDICINE

SEPTEMBER 1992 VOLUME 91, NO. 9

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

Family violence is a deadly public health crisis, reports the AMA, and physicians must become involved to help bring the violence to a halt. MSMS, in conjunction with the AMA, has launched a campaign to increase physician and public awareness about family violence. Included in this month's cover story are: a message from MSMS President Thomas C. Payne, MD; a recap of the first MSMS family violence forum; a rundown of the AMA family violence protocols; special reports on the three major categories of abuse (spouse, child and elder); a summary of abuse and neglect reporting requirements; a rundown of domestic violence legislation and a synopsis of pending bills; and a reference guide to emergency shelters by county.



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MSMS Annual Scientific Meeting

Cover illustration: By Robert L. Brent

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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SOUNDOFF!

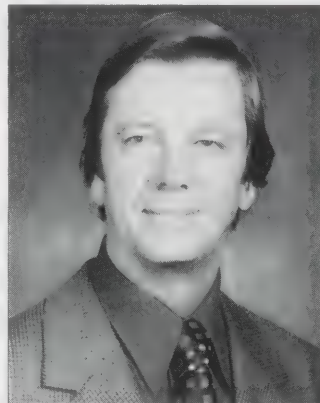
Soundoff! provides you with the opportunity to voice your opinion about any issue you please. If you have an opinion you would like to share with your colleagues, write it down and send it to *Michigan Medicine*, PO Box 950, East Lansing, MI 48826-0950 Attn: Betty McNerney. We will do our best to publish your comments in a timely manner.

Michigan's malpractice crisis victimizes many, including residents and postgraduate training programs

By Gerhard C. Endler, MD

In a recent malpractice judgment against Hutzel Hospital in Detroit, the plaintiff was awarded around \$5 million. The case involved a patient who developed obstetric complications that required several operations. In addition to a keloid-deformed scar, which can obviously be repaired as a scar from a previous operation actually was, plaintiff claimed damages related to the removal of the uterus as a result of the cesarean hysterectomy that needed to be done.

While the patient had a very rocky course, there is no doubt that prompt action on the part of everyone involved in the care of the patient, including staff physicians, residents and nurses, saved the patient's life and salvaged a healthy baby. In-house and outside review of the case determined that the care was absolutely appropriate.



Gerhard C. Endler, MD

After learning about the verdict, the entire obstetric resident staff erupted into disbelief, anger, and frustration. The residents who were part of the care team were particularly outraged. They did their best seeing the patient through her travail, they worried about her, they felt good as they should when the mother left the hospital with a healthy baby in her arms. In court they endured the theatrics and verbal mauling of Geoffrey Fieger, the plaintiff's attorney, and they felt that they had adequately explained their actions to the jury. However, as one juror commented following the trial, the physicians' testimony appeared too rehearsed because they all gave the same account of the events that took place.

As in this case, plaintiff will always be able to procure the services of an "expert" who makes a living giving depositions. Such testimony unfailingly will label course A as inappropriate and negligent if that approach leads to problems and declares course B as the one that should have been chosen. If course B had been carried out and caused complications, then

Continued on following page

Continued from page 5

naturally one should have used course A.

No-win situations difficult

While it is hard enough for seasoned medical practitioners to cope with these no-win situations, it creates total confusion and anguish in the minds of those still in the process of learning the practice of a medical specialty.

In the aftermath of this jury verdict, Hutzel's residents requested that members of their group be offered an opportunity to meet with the Hospital's Patient Care Improvement Committee. Composed of members of the Board of Trustees, top officials of Administration, and departmental chairmen, the committee deals with quality improvement matters and examines every incoming suit or claim as to whether generic problems exist that need immediate correction.

The meeting showcased the dilemma in which individuals undergoing training find themselves. They are exposed to a spectrum of educational signals ranging from a pure textbook to a defensive play-it-safe approach. When these young physicians go out and start their own practice, will the fear of litigation be intimidating enough to cause them to perform a cesarean section at the slightest hint of an abnormal fetal response, adding to a cesarean section rate that in comparison to other industrialized nations is already grotesquely high? Will they hesitate to take action when such action includes known risks?

The committee members could do no more than listen to the residents' concerns with great empathy. If instead their audience were legislators, they opined, perhaps

then they would be speaking to a group who does hold the power to bring about changes in Michigan's dismal malpractice climate. Thus was conceived the plan to have the two executive chief residents in the Department of Obstetrics/Gynecology invite area members of the Michigan House of Representatives to come to Hutzel and listen to the residents' plight. Such a meeting with legislators did in fact take place May 15, 1992. Also in attendance

“We now spend time learning about the legal aspects of medicine. The impression I take away from these classes is that I am going to get sued either way, if I am wrong or if I am right.”

were OB/GYN residents from Beaumont, Sinai, Oakwood, and Henry Ford hospitals, as well as Hutzel residents from the Departments of Orthopaedic Surgery and Pediatrics.

“We now spend time learning about the legal aspects of medicine. The impression I take away from these classes is that I am going to get sued either way, if I am wrong or if I am right,” said one resident. Added another, “People don’t understand that there can be bad outcome, no matter what precautions are taken.” One physician involved in the case mentioned earlier, a fellow in perinatology, told the group that “...it has discouraged me from practicing here. I am looking for an opportunity elsewhere.” And this last comment was perhaps the most telling one as it reflected the disen-

chantment of physicians in training with the professional climate that prevails in Michigan.


Residents are leaving state

In fact, the majority of this year's graduates from Hutzel's OB/GYN program are leaving the state. Having known these graduates for four years and having developed a great respect for their professionalism, dedication, and bright minds, it is very saddening to this writer to see them looking for better opportunities elsewhere.

In his comment, Rep. Joseph Young, Sr., described the current political climate in Lansing as it pertains to malpractice reform. A package, he believes, with which all parties involved in the issue - physicians, hospitals, insurance companies and plaintiffs - can live has a good chance of being passed by the House. Rep. Sharon L. Gire agreed with the call for a balanced approach and emphasized the need for physicians to become much more involved in the political process. Undoubtedly, a short course on political realities was a new subject for these young physicians, but one of real importance and immediate value.

The residents presented their views with eloquence, their statements were factual and very convincing. On balance, the meeting was productive in that it hopefully provided lawmakers with an opportunity to learn about the plight of the physicians in training whose optimism and high hopes must not be squashed during their formative years lest they enter practice in a mental frame of cynicism, defensiveness, and distrust, or turn their backs on Michigan altogether. ■

Doctor Endler is vice president, Medical Affairs, Hutzel Hospital, Detroit, and vice chairman, Greater Detroit Physician Executives Organization.



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LETTERS

MSMS physician's law guide receives letters of praise

Editor's note: Already individuals have sent letters to MSMS praising the Society's just-published "Physician's Guide to Michigan Law." The 106-page guide summarizes 80 Michigan laws that affect physician practices. A complimentary copy of the guide has been sent to all MSMS members. Additional copies are available to members at \$35 each, and to nonmembers at \$95 each. Following are two letters MSMS recently received about this new guide.

The purpose of this letter is to note a wonderful member service recently issued by the Michigan State Medical Society. It is a book entitled, "Physician's Guide to Michigan Law and Medical Practice Resources." As a county medical society which receives telephone calls from physicians and members of the public all day every day, this document has already become an invaluable resource. Thank you for producing this ground-breaking document.

Peter A. Levine, MPH
Executive Director
Genesee County Medical Society

Please let those responsible for compiling (the law guide) know that we will make frequent use of it in answering questions from our members. It covers the issues and arenas we are frequently asked about by our membership, so it will be a very useful tool.

Janet Fouracre
Oakland County Medical Society

Physician-assisted suicide "a moot" issue

I suspect that I am not alone when I express my frustration over the publicity given the subject of

physician-assisted suicide. My practice for the past 25 years has included the care of terminally ill patients and I have never been asked to relieve any patient's suffering by the administration of lethal medication. I am sure that my professional experience is the norm, and I fear that the Michigan State Medical Society has allowed itself to be drawn into a tempest in a teapot.

The message from MSMS to the press and legislators should be that this subject is moot. If we are not careful, the politicians in the State House will solve this non-existent problem with another set of rules and regulations which will serve only to further dehumanize the practice of medicine in this state.

Laurence LaGattuta, MD, FACS
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Helpline established for short statured/dwarfed people

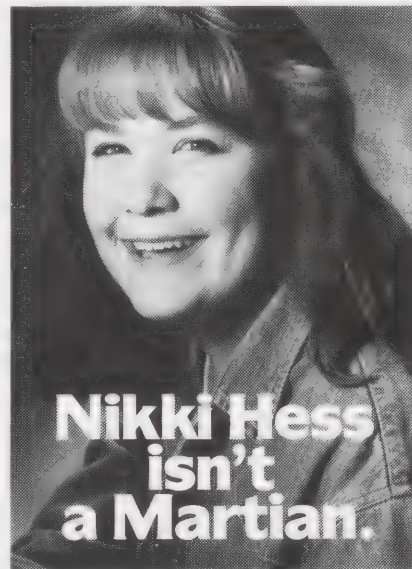
The Short Stature Foundation (SSF) was founded in 1984 as a public, non-profit, tax exempt organization in response to the suicide of 17-year-old Michelle Crandall, a dwarf. Her suicide note stated, "I cannot handle the life God gave me as a short statured person." The acute problems faced by the two million short statured/dwarfed people in the United States are often emotionally and physically overwhelming. Many feel socially isolated. Environmental systems are not designed to accommodate them.

The Short Stature Foundation has established a National 1-800-24 DWARF Helpline System which allows short statured/dwarfed people and their families to contact medical specialists, support groups and other needed services.

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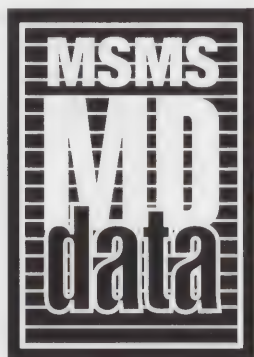
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Epilepsy Foundation of America

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MSMS SURVEY ON PRACTICE CHARACTERISTICS

“Physician heal thyself is a phrase we’ve all heard, but not too many of us are familiar with ‘physician know thyself.’ That’s what we’re going to try to accomplish this fall with a major survey of MSMS members. We’re trying to learn more about ourselves; who we are, where we are, what we do, what we want and what we need. If you are one of those selected at random to participate in this anonymous survey, please make every effort to complete the survey form accurately and return it to us quickly.

It’s amazing what you can learn through self examination.”

Thomas C. Payne, MD, MSMS President



This survey will provide Michigan physicians with data that are not available from other sources and will allow MSMS to have aggregate data on Michigan

physicians for advocacy and education. Surveys will be mailed to members in the first week of November. All individual responses will be confidential.

WATCH FOR THE SURVEY IN NOVEMBER



A monthly update of key MSMS activities

Michigan Medical Liability Reform Coalition plans fall public relations campaign

Significant public relations activities by the Michigan Medical Liability Reform Coalition will take place this fall in an attempt to influence campaigns for the Michigan House of Representatives. At its August 25 meeting, the Coalition agreed to a plan to raise the medical liability issue with voters in House districts across the state. The goal is to get voters to ask candidates their positions on medical liability reform and then vote for reform supporters. The theme of the public relations campaign is "Support candidates who support medical liability reform." The campaign will run from Labor Day through election day on November 3rd. Physicians are encouraged to publicly and financially support local House candidates who support medical liability reform. A letter to the editor of the local newspaper is an effective means to support such candidates. For more details about the plan or for more ideas on how to become involved in the public relations campaign, contact David Fox or Judy Marr at MSMS at 517-337-1351.

MSMS family violence forum starts dialogue on how physicians can help

Nearly 40 representatives of organized medicine, nursing, education, public health, law enforcement, and the media took part in a first-of-its-kind forum on family violence sponsored by MSMS August 19.

Led by MSMS President Thomas C. Payne, MD, East Lansing, the forum was intended to spur discussion on what physicians and MSMS can do to help combat this difficult problem. Among those who attended the forum were representatives from: the Michigan Department of Public Health, including Director Vernice Davis Anthony; the Wayne State University College of Nursing; the Michigan State University College of Osteopathic Medicine; the Michigan Education Association; the Michigan State Police; the State Bar of Michigan; the Michigan Judges Association; the Michigan Psychoanalytic Society; the Office of Services to the Aging; and the Michigan Department of Social Services Domestic Violence Prevention and Treatment Board. Because discussions went so well, another forum is planned for this fall. An MSMS mailing announcing the date will be mailed to meeting participants this month. For further details, contact Judy Marr at MSMS (517) 336-5744.

MSMS to begin five-part medical biller training series this month

New medical billers can receive training geared toward Michigan rules and payers through an MSMS program that will start later this month. The five-part series will be conducted in concert with Medical Management Systems of Michigan, a billing reimbursement and consulting firm. The price for the entire 11-day series is \$1,250, which includes workbooks and lunch. Participants may take individual classes in the series at a cost of \$375 for "Introduction to Billing" and \$300 for the other sessions. Classes, which will be held at the Pretzel Bell Restaurant in East Lansing, are limited to 30 people in each session. Call Angela LaBonville at (517) 336-5723 for more information.

For details on these and other issues call William E. Madigan, Executive Director, MSMS, 517/337-1351

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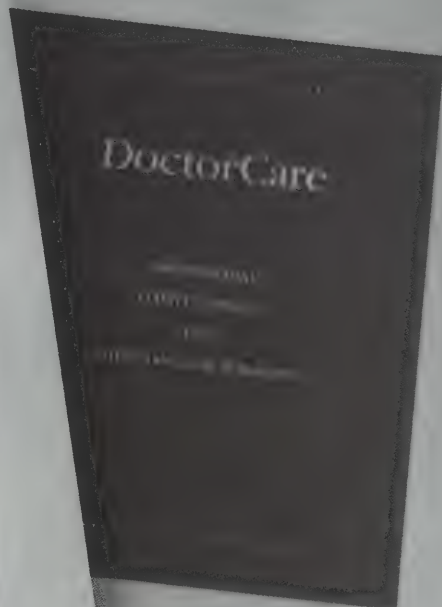
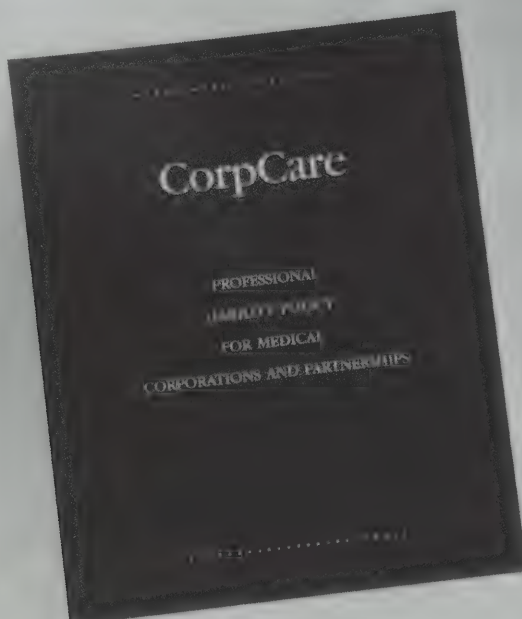
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County Medical Societies **ON THE GO**

Michigan Medicine is pleased to feature this column which highlights the activities of county medical societies in Michigan. If the activities of your county medical society are not mentioned in this feature -- and you have some news you would like to share -- please contact Helen Fordham at MSMS.

Washtenaw County

A special issue of the Washtenaw County Medical Society *Bulletin* pays tribute to John Lawrence Kemink, MD, the physician shot and killed by a patient in the ENT clinic of the University of Michigan Hospital June 25. Included in the 13-page edition are four articles, a president's column and an opinion piece by *Bulletin* editor Karl J. Edelman, MD. (Vol. 43, No. 11)

Genesee County

The Genesee County Medical Society Free Clinic will remain open. There was a threat of closure

when state funding was eliminated. MSMS and MPMLC have, however, secured medical malpractice coverage for the next year allowing the clinic to remain open.

Kent County

Kent County Medical Society will hold its first mini-internship September 20-22. The project will provide local news media and corporate CEOs the opportunity to "walk in physicians' shoes." It is anticipated that six interns will be selected and they will complete four half-day rotations.

Ingham County

The Health Care Task Force of the Ingham County Medical Society has developed a plan which outlines what the Task Force members feel are necessary reforms in health care delivery. The comprehensive plan addresses the definition of basic health care through patient responsibility, physician accountability, societal determinations and cost evaluations. Candidates for State Representative in the 67th, 68th, 69th, 70th and 71st Districts will be invited to discuss the Health Care Plan at a forum held at the regular society meeting in October.

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MPMLC dedicates library to Robert M. Leitch, MD

Michigan Physicians Mutual Liability Company (MPMLC) has dedicated the "Robert M. Leitch, MD, Memorial Library" and installed a plaque in honor of the Battle Creek physician who died September 14, 1990, at the age of 72.

Doctor Leitch was a founder of MPMLC and served on its board of directors from 1976 to 1988 when he resigned for health reasons and was given the honorary title "president emeritus."

He had been president and chairman of the board from 1980 to 1988. As president, Doctor Leitch guided MPMLC through the severe malpractice insurance crisis of the 1980s and laid the groundwork for the company's financial recovery.

Doctor Leitch is a past president and past secretary of MSMS.

MSU earns \$2.27 million grant for cancer care

Researchers from Michigan State University and health care professionals from around the state will use a \$2.27 million grant from the National Cancer Institute to provide comprehensive cancer care in underserved areas of southwest Michigan.

The five-year grant, titled "Rural Partnership Linkages for Cancer Care," was awarded to the College of Human Medicine's Department of Family Practice, the MSU College of Nursing and the Cancer Center of MSU.

Working with local hospitals and clinics and the MSU departments and colleges will be the Kalamazoo Community Oncology Program (KCOP) and the MSU/Kalamazoo Center for Medical Studies.

Among the goals of the project are to provide better physical and psychological care for patients and their families, expand existing community services, and improve referrals to community physicians for follow-up care.

AMA provides HCFA with RBRVS update recommendations

The American Medical Association has established a process for developing relative values for new or revised codes in the *Current Procedural Terminology*.

The AMA/Specialty Society Relative Value Scale Update Committee, or RUC for short, will provide recommendations for HCFA to use in updating the new Medicare resource-based relative value scale physician payment schedule. RUC is composed of physician representatives from the AMA, 22 medical specialties, American Osteopathic Association and the CPT editorial panel. RUC will hold three or four meetings in 1992 and 1993 to prepare for the 1994 CPT.

800-number for Alzheimer's information

The Alzheimer's Disease Education and Referral Center has a new toll-free telephone number for Alzheimer's information. It is 1-800-438-4380.

By calling this number, health professionals and the public can:

- ask questions about Alzheimer's disease
- identify resources and materials
- receive a calendar of upcoming conferences
- learn about NIA-sponsored clinical trials
- order **free** publications

Two publications are available:

■ **1992 Progress Report on Alzheimer's Disease.** This publication summarizes key findings from the National Institute on Aging programs and other NIH researchers during the previous year. The report describes basic brain structures and how they are affected by Alzheimer's disease.

■ **Alzheimer's Disease Q & A.** This publication answers commonly asked questions about Alzheimer's disease. It provides information about symptoms, diagnosis, causes, and treatment and includes a glossary.

The Alzheimer's Disease Education and Referral Center is a service of the National Institute on Aging. The Center was established in 1990.

Arthrocentesis conference available on videotape

The University of Washington School of Medicine has made available the videotape version of "Arthrocentesis & Injection Techniques For The Primary Care Physician," a national conference presented by leading physicians in the field. This home study course is approved for 2.5 CME Category I credits of the Physicians Recognition Award of the American Medical Association.

CME credit is obtained after successful completion of a self examination which accompanies the course. Cost of the course is \$125, plus \$13 shipping and handling.

For more information about course content or to place an order, call 1-800-284-8433 or 1-609-427-0838. Or write CME Conference Video, Inc., 1916 Old Cuthbert Rd., B-13, Cherry Hill, NJ 08034-1457.

Continued on following page

Continued from page 15

AMA launches "Healthy Youth 2000" campaign

The American Medical Association, in cooperation with the American Academy of Pediatrics, has announced a campaign designed to promote the health of America's youth.

"Healthy Youth 2000" is part of the AMA's effort to support "Healthy People 2000," a broad-based plan designed by the US Public Health Service to increase Americans' healthy life span. The youth program will run several years.

Physician enrollment applications and campaign updates will appear in AMA and AAP journals, other medical publications and on American Medical Television in the first year. This fall, ABC's "HOME Show" will air segments on youth health issues. The February 1993 issue of *Good Housekeeping* magazine will include a special supplement highlighting "Healthy Youth 2000."

Brochures, books, audio-cassettes and videos will be developed for use by children, adolescents and their care-givers. Some 2.5 million brochures detailing immunization information in English and Spanish/English are now being distributed to US physicians.

MDPH receives CDC grant to prevent lead poisoning

The Michigan Department of Public Health (MDPH) has been awarded a "Childhood Lead Poisoning Prevention" grant from the US Centers for Disease Control (CDC).

The five-year, \$415,000 per year, grant will assist the Bureau of Child and Family Services in identifying and tracking children with elevated blood lead levels. The grant will be used to develop a comprehensive plan to reduce the number of lead

poisoning cases in Michigan.

For additional information, please contact Paulette Dunbar at (517) 335-8903.

First statewide substance abuse program for the hearing impaired underway

The Salvation Army's Harbor Light Center, the Michigan Coalition of Agencies and Organizations Serving Deaf and Hard of Hearing Persons, and the Michigan Department of Public Health's Center for Substance Abuse Services (CSAS) have teamed up to offer the first statewide substance abuse program for Michigan's deaf and hearing impaired persons.

Michigan and Minnesota are the only states in the Midwest with a substance abuse treatment program for the deaf and hearing impaired.

The 15-month program, which began July 20, is funded by a CSAS grant. Those who participate in the 35-day program will live at The Salvation Army's Harbor Light Center in Monroe, and will participate in an intensive substance abuse treatment program at the Harbor Light Center's out-patient facility, also in Monroe.

The substance abuse rehabilitation program consists of detoxification services, counseling, referral services, and follow-up.

AMA urges OSHA to change standards

In response to policy adopted at the recent AMA Annual Meeting, the AMA has asked the House Labor/HHS Appropriations Committee to require the Occupational Safety and Health Administration (OSHA) to make changes in its bloodborne pathogen standard. The Association sent letters to Committee Chair William Natcher (D,Ky.) and ranking minority member

Rep. Carl Pursell (R-Mich.) calling for OSHA to:

- Reconsider its penalty structure.
- Conduct a cost/benefit analysis of the standard as it applies to physician practices.
- Reduce the 30-year recordkeeping requirement.
- Adopt a one-year grace period for physicians who are making good-faith efforts to comply.

New U-M center to enhance genetic research

The University of Michigan Medical Center has established a new center to enhance gene discovery and gene therapy.

The center will strengthen research through better coordination, management and support for research teams hunting for genes and devising gene therapies. Its goal is to foster fruitful collaboration among investigators from many departments across the Medical Center; within the center they will share not only expertise but also specialized technical resources to make their work more efficient.

The center will support educational programs, ethical studies and patient treatment programs. While ethical and educational issues of genetic technology already are addressed by the existing Genome Ethics Committee and other activities, the new center will broaden educational efforts and link them to philosophical and ethical issues relevant to genetic research. In addition, a program will be developed to disseminate information about the clinical benefits of DNA testing and human gene therapy.

The center also will promote development and outreach activities. It will serve as a link between the federal government, foundations, private organizations and patient

MEDICAL NEWSFRONTS

groups who can promote and sponsor the University's efforts to take molecular biology advances from the lab to the bedside.

U-M performs first direct human gene transfer

The world's first gene therapy trial using direct transfer of modified human genetic material into the body to treat human disease has been performed at the University of Michigan Medical Center.

This trial also represents the first in which a non-viral vector, in this case liposomes, was used to deliver a therapeutic gene. Viral carriers had been used in all gene therapy experiments to date.

On June 4, U-M researchers injected a gene into a tumor of a patient with malignant melanoma. The goal is to trigger an immune response that will destroy tumors.

This streamlined approach, known as *in vivo* gene therapy, differs from previous gene therapy techniques that remove cells, insert genes in the laboratory and return the modified cells to the body.

The patient was a 67-year-old female from Michigan. She tolerated the procedure well, remained in good condition and was discharged from University Hospital according to plan.

Beaumont study supports long-term effectiveness of very-low-calorie diets

National talk show host Oprah Winfrey is the most visible symbol of the phenomenon known as "Yo-Yo Dieting." Her much-publicized weight regain, after a very-low-calorie diet (VLCD), did much to feed the viewpoint that people who lose weight, gain it all back

again, and that VLCD programs are just a temporary solution in a life-long battle of the bulge.

But a study by researchers from William Beaumont Hospital's Division of Preventive and Nutritional Medicine in Birmingham, published in the August 1992 edition of the *International Journal of Obesity*, proves otherwise.

The 3.3 year follow-up study of 118 patients who completed eight weeks of VLCD therapy found that 75 percent of the patients kept off an average of 43 pounds; and 20 percent averaged 100 pounds of weight loss after three years. The total study population of 118 patients, who achieved an average weight loss of 69 pounds during VLCD treatment, maintained a weight loss of 30 pounds in the follow-up study. ■

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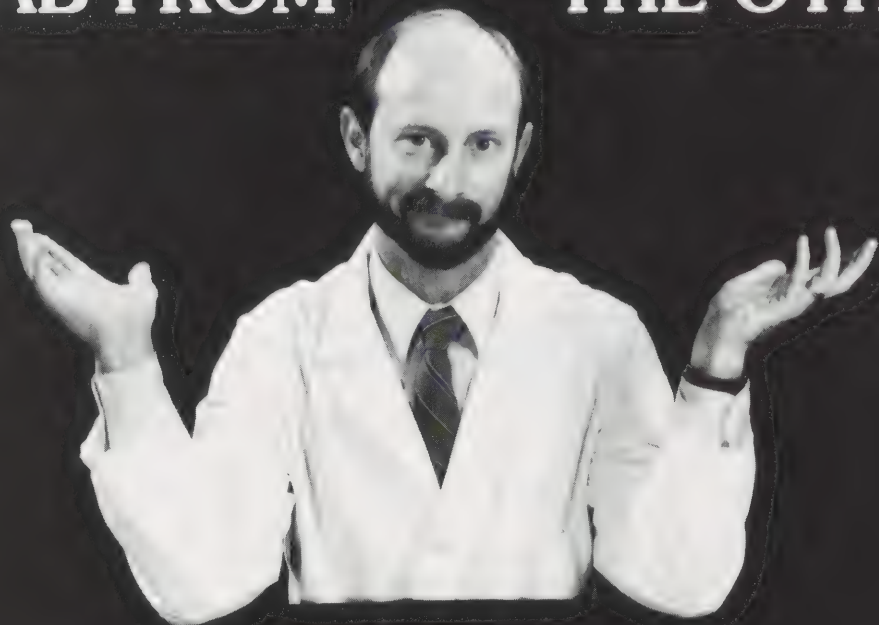
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PHYSICIANS IN THE NEWS



Vice President Dan Quayle was a featured luncheon speaker at the 10th Annual Convention of the American Association of Physicians from India (AAPI) held in June in Dearborn. Vice President Quayle (above left) took a moment to congratulate AppaRao Mukkamala, MD, (right) on his inauguration as president of the AAPI.

AppaRao Mukkamala, MD, *elected president of national organization*

AppaRao Mukkamala, MD, a Flint radiologist and chairman of the MSMS Section for International Medical Graduates, is the newly-elected president of the American Association of Physicians from India. In his inaugural address, Doctor Mukkamala told approximately 3,500 physicians and guests: "We should be satisfied with our achievements to date, which have been mostly confined to fighting discrimination against international medical graduates (IMGs)... However, IMGs should play a key role in paving the future state of American health care policy." Doctor Mukkamala also said: "Only by being actively involved (in the political process) can we have our input before policies are formed. We should become proactive rather than reactive. We should not confine our involvement to medical issues but rather to issues of public interest also." Doctor Mukkamala is secretary of the Genesee County Medical Society, chairman of the Hurley Medical Center Radiology Department, and secretary of the Hurley Medical Center medical staff.

Louis E. Sanford, MD,

a Belding family physician, was recently named Michigan's 1992 Family Physician of the Year by the Michigan Academy of Family Physicians. Doctor Sanford is a graduate of the University of Michigan Medical School, is a Charter Fellow of the American Academy of Family Physicians and is Board Certified in Family Practice. He has been in private practice in Belding for 30 years and is active in numerous local, state and national organizations.

Charles F. Whitten, MD,

is newly-named Associate Dean of Special Programs at Wayne State University School of Medicine. Doctor Whitten, a graduate of Meharry Medical College in Nashville, is well known for his work in the field of sickle cell anemia and was president of the National Association for Sickle Cell Disease for 18 years. He is active in many organizations, boards and committees at the local, state and national levels.

Robert Frank, MD,

is newly-named Associate Dean for Academic and Student Programs at Wayne State University School of Medicine. Doctor Frank is a graduate of Wayne State University School of Medicine, is an active member of many professional societies and has received numerous awards for his service to the medical profession.

Kevin M. Fickenschner, MD,

assistant dean and president/CEO, Michigan State University Kalamazoo Center for Medical Studies, has been appointed as the American Hospital Association representative to the National Resident Matching Program. During his three-year appointment, Doctor Fickenschner will represent the interests and policies of the nation's teaching hospitals in the resident placement process. A medical graduate of the University of North Dakota, Doctor Fickenschner is a member of the National Advisory Committee on Rural Health for the US Department of Health and Human Services, was selected as a Kellogg National Fellow by

Continued on following page

Continued from page 19

the WK Kellogg Foundation and was named a 1991 *Emerging Leader in Health Care* by Healthcare Forum.

George L. Blum, MD,

is newly-elected president of the Michigan Chapter of the American Academy of Pediatrics. Doctor Blum is in private practice in Southfield and is a clinical associate professor of pediatrics at Wayne State University School of Medicine.

W. Patrick Mazier, MD,

a Grand Rapids colorectal surgeon, is newly-elected president of the American Society of Colon and Rectal Surgeons. Doctor Mazier, a graduate of the University of Western Ontario, will serve a one year term. He currently practices with five colorectal surgeons at the Ferguson Clinic for Digestive Diseases, Grand Rapids.

Ian T. Jackson, MD,

a Southfield plastic surgeon, is recipient of the "Clinician of the Year Award" from the American Association of Plastic Surgeons. Doctor

Jackson has been included in the publication, "Best Doctors in America" and is author of numerous books and published articles.

N. S. Rangarajan, MD,

a Detroit obstetrician/gynecologist, is newly-named group vice president and medical director of The Wellness Plan. Doctor Rangarajan has been with The Wellness Plan since 1977 as a member of the New Center Medical Plaza Group, PC.

John Armstrong, MD,

is the recipient of the "Distinguished Community Volunteer Faculty Award" from Michigan State University's College of Human Medicine. The award is given to "those who have demonstrated excellence in teaching, research, or service. Doctor Armstrong, a pulmonologist and critical care physician, was selected from over 100 members of volunteer faculty over the six MSU campuses. ■

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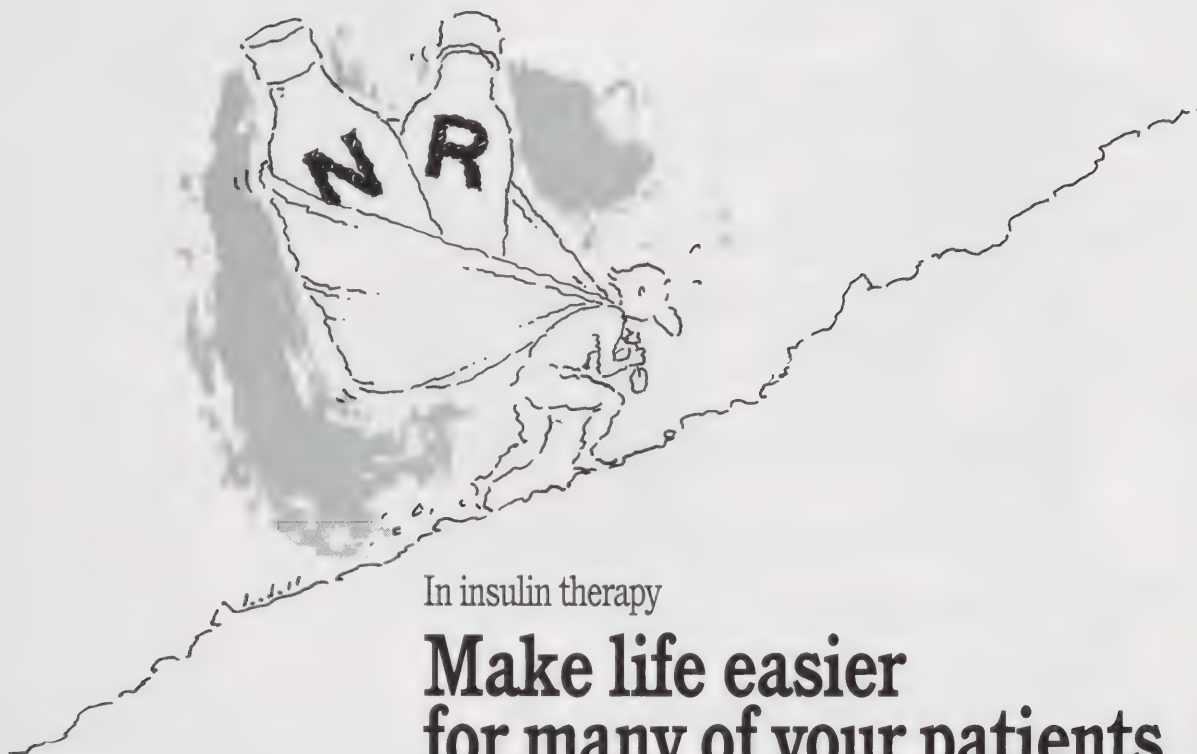
New OSHA standards require Michigan physicians to provide free hepatitis B vaccines to all employees exposed to bloodborne diseases.

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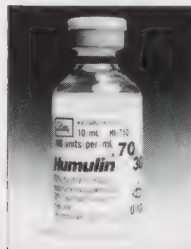


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Cover
Story

DOMESTIC VIOLENCE

Physicians can play a key role in helping stop the cycle of violence

Family violence is a deadly public health crisis, reports the AMA, and physicians must become involved to help bring family violence to a halt. MSMS, in conjunction with the AMA, has launched an educational campaign to increase physician and public awareness of family violence. This special report on domestic violence begins on page 24 with a message from MSMS President Thomas C. Payne, MD, about the MSMS campaign. Following his address are: a recap of the first MSMS family violence forum; a rundown of the AMA family violence protocols; special reports on the three major categories of abuse (spouse, child and elder); a summary of abuse and neglect reporting requirements; a rundown of domestic violence legislation and a synopsis of pending bills; and a physician's guide to emergency shelters by county. ►

MSMS launches family violence educational campaign

By Thomas C. Payne, MD
MSMS President

MSMS has the opportunity to lead Michigan in lessening the incidence of family violence, to identify those at risk for perpetrating violence and for being victimized, and to provide help to both. MSMS, in addition, is the most appropriate organization to educate Michigan physicians about diagnosis and treatments for violence-prone families, and the resources and services available for those families.

In doing so, MSMS is helping implement the nationwide campaign announced in October 1991 by the American Medical Association, to involve physicians in preventing family violence and providing help for the victims of child, adult and elder physical and sexual abuse. AMA Board Vice Chairman Robert E. McAfee, MD, has taken the lead in the national education campaign.

"The AMA recognizes family violence as a deadly public health crisis," says Doctor McAfee. "Physicians see its victims every day -- and are in a crucial position to help stop the cycle of violence."

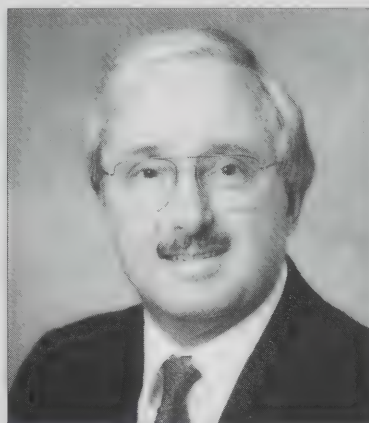
"AMA research shows that 80 percent of Americans feel they could tell a physician if they had been either a victim or a perpetrator of family violence. The patient's trust is there. What's needed are the right tools for the physician."

Surgeon General Antonia Novello, MD, reports that more than two million cases of child abuse and neglect are reported each year, though many more are not reported. The National Crime Survey puts the annual medical costs of domestic violence at almost 100,000 days of hospitalization, almost 30,000 emergency room visits, and almost 40,000 visits to a physician each year. As many as 35 percent of women who visit hospital emergency rooms are there for symptoms related to ongoing abuse. Yet as few as five percent of domestic violence victims are identified as such, she says.

Doctor Novello calls for America's doctors to move to the front lines in recognizing, treating and preventing domestic violence, as they have been in dealing with its consequences, and to become as active in the prevention and treatment of victims of sexual, spousal and elder abuse as they have been with victims of child abuse.

At my MSMS presidential installation, I declared that a crusade against family violence would be a cornerstone of my term in office. Since then, I have met with AMA officials, and leaders across the state to further research the possibilities, and to formulate plans to carry out the campaign. Key in my plans is cooperation with the MSMS Auxiliary, which has joined the AMA

"At my MSMS presidential installation, I declared that a crusade against family violence would be a cornerstone of my term in office."



Doctor Payne

Auxiliary in making this issue a prime focus of attention.

Following are the activities I have set in motion:

- MSMS has joined the AMA's National Coalition of Physicians Against Family Violence, and has begun urging individual Michigan physicians to do so, also. (See page -- for list of Coalition members.) Those who join receive a mission statement, membership card and a poster expressing the physician's concern and offer of help, for display on office walls. They also receive newly-developed AMA protocols for recognition and treatment of child sexual and physical abuse and domestic abuse. A fourth protocol, on elder abuse, is due in October.
- Together with the MSMS Auxiliary, MSMS has begun assessing and listing referral services throughout Michigan for physicians' patients. (See page -- for list of shelters by county.)
- I invited representatives of a variety of Michigan health, legal and law enforcement organizations, as well as the Michigan Coalition Against Domestic Violence, Blue Cross Blue Shield of Michigan, New Detroit and "safe houses," to a meeting held August 19 at MSMS headquarters, to outline for them MSMS concerns and goals, and to seek their input on their own activities and recommendations for physician action. (See page -- for highlights of this meeting.)
- MSMS will present three half-day courses at the 1992 Annual Scientific Meeting to assist physicians in recognizing and treating victims of family violence. (See sidebar for more information.)
- The day preceding the Annual Scientific Meeting, MSMS plans to present a public seminar with expert speakers from the AMA, and other national and statewide sources. MSMS has invited the speakers to

remain in Dearborn for the night, and to be part of the Annual Scientific Meeting program the following day.

Michigan is blessed with being the home state of several key players in the national campaign. They include:

- Elissa Benedek, MD, Ann Arbor, newly-named chairman of the AMA Advisory Committee on Family Violence.
- James O'Brien, MD, chairman, AMA Elder Abuse Working Group.
- Rhoda M. Powsner, MD, MSMS board member, Washtenaw County Medical Society president and AMA delegate, member, AMA Advisory Committee on Family Violence. Doctor Powsner has organized two excellent public forums in Washtenaw County which have served as my models for galvanizing cooperation of the spectrum of concerned groups.

We will, of course, include Doctors Benedek, O'Brien and Powsner as major members of our campaign.

I am truly excited about the opportunity to make a difference for Michigan physicians and our patients through this educational project. As one of the speakers in a Medical Student Section program at the 1992 AMA Annual Meeting noted, physicians may have been the weak link in the chain of help for victims of abuse and their abusers. It is time that we strengthen our resolve to understand, to intercede and to bring help to those in need of protection and those who need to learn to rechannel their frustrations and aggression. Our increasingly-violent society demands this help perhaps more than any other if we are to advance as a civilized nation. ■

"The AMA recognizes family violence as a deadly public health crisis. Physicians see its victims every day — and are in a crucial position to help stop the cycle of violence."



Doctor McAfee

MSMS family violence forum starts dialogue on how physicians can help

Another forum slated for this fall

Nearly 40 representatives of organized medicine, nursing, education, public health, law enforcement, and the media took part in a first-of-its-kind forum on family violence sponsored by MSMS August 19.

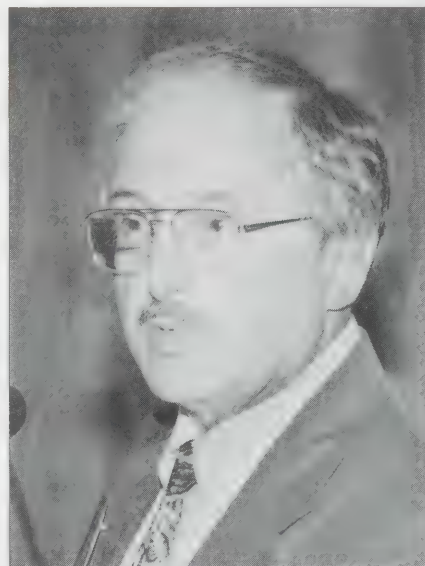
Led by MSMS President Thomas C. Payne, MD, East Lansing, the forum was intended to spur discussion on what physicians and MSMS can do to help combat this difficult problem. Among those who attended the forum were representatives from: the Michigan Department of Public Health, including Director Vernice Davis Anthony; the Wayne State University College of Nursing; the Michigan State University College of Osteopathic Medicine; the Michigan Education Association; the Michigan State Police; the State Bar of Michigan; the Michigan Judges Association; the Michigan Psychoanalytic Society; the Office of Services to the Aging; and the Michigan Department of Social Services Domestic Violence Prevention and Treatment Board. "We were successful in getting nearly every major player on the issue to sit down and talk about it," said Doctor Payne.

The group discussed the need for education among its own representatives about what the other groups are doing about family violence. There was a strong consensus that legislation is needed to better detail reporting requirements. The 10 physicians present requested improvements in their access to

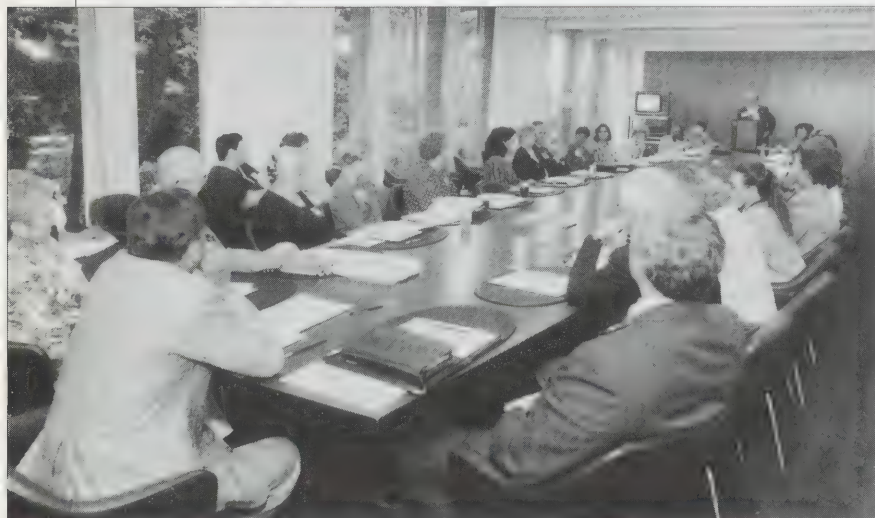
the family violence prevention system in this state. They outlined a need for faster access, which would allow them to more quickly and easily refer patients to the proper resources for help.

Discussions went so well that another forum is planned for this fall, said Doctor Payne. An MSMS mailing announcing the date will be mailed to meeting participants this month. "We're considering breaking the group into subgroups at the next meeting," said Doctor Payne. That's so the group can better focus in detail on the many aspects of family violence, he noted, including legislation, education and law enforcement. For further details on the forums, or if you are interested in attending, contact Judy Marr at MSMS (517) 336-5744. ■

"We were successful in getting nearly every major player on the issue to sit down and talk about (domestic violence),"
said MSMS President
Thomas C. Payne, MD, who
headed the MSMS forum.



Nearly 40 representatives of organized medicine, nursing, education, public health, law enforcement, and the media took part in a first-of-its-kind forum on family violence sponsored by MSMS August 19.



AMA issues first three physician protocols on family violence

Fourth set on elder abuse to be completed by October

The AMA has completed three of four guidelines planned to help physicians deal with family violence.

The new protocols, drafted by both AMA staff and outside experts, deal with treatment of child sexual abuse, child physical abuse, and domestic violence between partners.

Printed in pocket-sized format, the protocols were sent late this summer to individual members of the AMA's national coalition against family violence as well as to all state, county and specialty societies; to hospital medical staff services; and to group practices.

The fourth set of protocols, on abuse of the elderly, is

being developed and is scheduled to be completed by October.

The protocols are a key element of the AMA Physician's Campaign Against Family Violence, launched last October.

Other major planks in the program are the national coalition against family violence, which physicians are being asked to join; an information clearinghouse to help doctors better coordinate efforts with law enforcement, mental health, and the judicial fields; and the AMA Auxiliary's program to educate the public, support victims and provide doctors with a list of resources for patients. ■

What physicians can do

Excerpts from the AMA protocols on handling family violence

CHILD SEXUAL ABUSE

When interviewing a child, a physician should:

- sit near the child, not across a desk, and sit at the child's eye level.
- Conduct the interview in private, without the caretaker present.
- Find out who else has questioned the child.
- Use the child's own words and terms wherever possible.

Do not:

- Suggest answers.
- Leave the child unattended or with unknown persons.
- offer rewards to the child.

When interviewing caretakers:

- Reserve judgment.
- Attempt to be objective.
- Explain further actions that will be required.

Do not:

- Attempt to prove abuse.
- Pry into unrelated family matters.
- Give feedback on the caretaker's explanation of how the injury occurred.

CHILD PHYSICAL ABUSE

Certain types of injuries are more commonly associated with abuse: the injuries are not explained by the history, are often located on multiple body sites and often are in various stages of healing. However, the medical recognition of abuse may be based on a single injury.

Physical findings that may be indicative of physical abuse:

- Bruises and welts:
Forming regular patterns often, often resembling the shape of the article used to inflict the injury.
- Burns:
Cigar or cigarette burns, especially on the soles, palms, back of buttocks.
- Immersion burns.
- Lacerations or abrasions:
Rope burns, particularly on wrist, ankles, neck, torso.
To palate, mouth, gums, lips, eyes, ears.
To external genitalia.

Behavioral findings of abuse include:

- Impaired interpersonal relations.
- Role reversal.
- Excessive household responsibilities, including child care.

SPOUSE ABUSE

Once abuse is recognized, a number of interventions are possible, but even if a woman is not ready to leave the relationship or take other action, the physician's recognition of her situation is important. Optimal care also depends on the physician's knowledge of community resources that can provide safety, advocacy and support.

Thorough medical records are essential for preventing further abuse and may prove crucial in a legal case. Records should include:

- Chief complaint and description of the event using the patient's own words.
- An opinion on whether the injuries were adequately explained.
- If the police are called, the name of the investigating officer and actions taken.

Photographs are also valuable; the physician should ask the patient for permission to take photographs:

- When possible, take photographs before the treatment is given.
- Use color film, and a color standard.
- Hold up a coin, ruler or other object to illustrate the size of an injury.
- Include the patient's face at least once.

Spouse Abuse:

The statistics are staggering

By Helen Fordham

Domestic violence is the single largest cause of injury to American women, according to a recent Surgeon General's report. It has been further estimated that a woman is beaten every 15 seconds and that women are nine times more at risk of being assaulted in the home than in the street. These frightening statistics are just the tip of the iceberg in isolating the magnitude of the domestic violence problem.

Domestic violence is more than an adult or child being victimized in an abusive relationship, explains Genesee County internist, Doris Suci, MD. "It is a major health problem that is responsible for miscarriages, birth defects, mental health problems, substance abuse and suicide," she says. A recent Harvard Law School study indicates that more birth defects are caused by battering than all other diseases.

Head of the Genesee County Coalition Against Domestic Violence, a group that provides advocacy and counseling to abused women, Doctor Suci had not always been aware of domestic violence. "When I first started working in emergency rooms I saw some egregious cases of abuse," recalls Doctor Suci, "including a little boy stabbed to death by his mother."

It wasn't until 1983, when Doctor Suci's office manager brought in a friend who had been savagely beaten by her husband, that she became sensitized to the issue.

Doctor Suci has learned that domestic violence is a pervasive societal problem. "Stereotypes and myths that help us not help the victims are rampant," she says. "I hear all the time that (the victims) must like (abuse) because they go back." This attitude diminishes the problem and paralyzes any real action in helping these women.

A complex set of financial, emotional and psychological factors can keep adults, in particular women, bound in abusive relationships, says Doctor Suci. Some blame themselves and take responsibility for the situation. Some don't consider themselves abused, while others are embarrassed. Often they love their abuser and remain with him in the hope that he will get better. More often than not they are in constant danger, explains Doctor Suci, and cannot run the risk of antagonizing their partner by leaving him.

The lack of support from society produces a negative attitude to the victims of domestic abuse, says Doctor Suci, and this often deters people from admitting they have been beaten. Yet, the authorities cannot help

victims of spouse abuse until they ask for help themselves. Asking for help, however, is often not a solution either.

"When the victim finally asks for help, they may have been put down by the people we tell them to turn to for assistance," says Doctor Suci. She believes her role as an advocate is to help these women who have been handled unfairly by the system. "We give them the tools and advice to deal with a recalcitrant system," she says.

Doctor Suci, while condemning aspects of the system, also appreciates the complexity of identifying and treating domestic abuse. She recognizes that women frequently return to the men who beat them and this can be frustrating for those trying to help them. But she believes that abused women can be helped and that physicians can play an important role in breaking the cycle of violence. "They (physicians) have the capacity and the ability and education to do something far broader than any other profession in helping to address this issue," she explains. "Even the most vulnerable person can feel safe with a physician," says Doctor Suci.

Helen Fordham is chief of community relations for MSMS.

MSMS legal counsel advises physicians to report cases of suspected adult abuse

Kerr, Russell and Weber, counsel to MSMS, advises that physicians have a duty to make an oral report to the County Department of Social Services when they suspect that a vulnerable adult is being, or has been, abused, neglected or exploited.

The only guidance given physicians about who is a "vulnerable" adult is a broad statutory definition. Under that definition, a "vulnerable" adult is one with a condition which renders the adult unable to protect himself or herself because of a mental or physical impairment, or because of advanced age.

Accordingly, when a physician comes into contact with a potentially vulnerable adult whom he or she suspects has been abused, the physician should contact the County Department of Social Services, and describe the age, the physical or mental condition of the adult, and the type of abuse, neglect or exploitation suspected.

If the Department then informs the physician that this is a reportable incident, the physician should complete the report, and maintain documentation regarding the date and time DSS was contacted, and with whom the physician spoke.

By following these procedures, the abuse statute specifically provides that any communication by the physician will not be a violation of the physician-patient privilege.

Child Abuse:

Physical neglect the most common form

By Helen Fordham

Elissa Benedek, MD, an Ann Arbor forensic psychiatrist, has seen children as young as 18 months sexually abused by parents. She knows children that have been beaten, drugged, raped, tortured and shaken. "It defies your imagination the things people do to children," she says.

A counselor to both victims and abusers, Doctor Benedek became involved in child abuse during her residency at Huron Valley Children's Clinic in Flint. It was here that she came into contact with children who were the victims of domestic violence and sexual abuse. "I heard so much from the children," she says. This was back in the 1960s, she recalls, when the medical profession was just beginning to get an idea of the problem.

It was this experience, coupled with a sudden spate of stories about people who had been arrested for abuse, that further motivated Doctor Benedek to become involved in child abuse cases.

During her 20 years as a psychiatrist, Doctor Benedek has seen adults who abuse their children for all sorts of reasons. Often it is part of a cycle of violence, she explains, since abusers were generally abused as children. Poverty, marital discord, economic strains and abuse of drugs and alcohol also tend to accompany the abuse, she says.

Abuse is not usually a conscious decision, according to Doctor Benedek. Not one of the people she counsels say they deliberately set out to abuse. They say they do it to teach, train, discipline and punish.

Doctor Benedek has found that some of her patients, many of whom are court-referred, can rationalize any act. She has heard some of them say, "She was asking for it, she was seductive," even if the victim was a four-year-old child. "The rationalizations are mind boggling," she says.

There is no typical profile of an abuser, according to Doctor Benedek, although it has been determined that women are more likely to abuse infants while men are more likely to abuse older children.

Abuse is defined as the intentional maltreatment of a child, says Doctor Benedek. This encompasses violent acts, emotional abuse and failure to provide care. Physical neglect is by far the most common form of abuse, according to statistics released by the Michigan Children's Protective Services.

According to Marsha Porter-Carter, supervisor of Ingham County Protective Services, society is more sympa-

thetic to child abuse. "It is different with children," she says, "because they are seen as vulnerable and they have no resources to get away from the situation."

Because of this vulnerability, authorities rely on others to report cases of suspected abuse. Physicians are therefore mandated by law to report any suspected abuse to the Department of Social Services (DSS). They are civilly liable if they fail to do this. In turn, DSS is required to carry out a prompt investigation.

Not enough cases are reported

Despite this affirmative duty to report, the incidence of child abuse is very under-reported, says Doctor Benedek. She has found that most psychiatric cases have a component of abuse in them, which indicates the scope of the problem.

It is very important that physicians report any suspicion of abuse, says Doctor Benedek. Their suspicions will override anything that the child and parent say, because often both will deny any abuse.

In cases of physical child abuse a detailed physician's medical report is very important in substantiating the child's injuries, says Porter-Carter. It is difficult for protective services officers to detect abuses like sexual abuse, she explains, so we need the evidence supplied by a doctor.

Physicians need to watch for abuse

Physicians need to watch for abuse all the time, says Doctor Benedek. "It (abuse) needs to be put in with the list of primary care considerations," she says. People don't want to accept that it happens and will accept all sorts of rationalizations for multiple injuries.

"There currently aren't diagnostic lists of questions for children," says Doctor Benedek. She suggests that if a physician suspects a child is being abused, they need to ask the child, preferably alone, whether anyone has been touching or hurting them or has been doing things to them they don't like. Physicians should be suspicious if the child appears to be accident prone, she says, or if there are re-occurring patterns of abuse.

Physicians are important agents of social change, says Doctor Benedek. "If we don't take responsibility, then we will be just like the abusers." We need to report, she stresses, or there won't be any change. ■

Helen Fordham is chief of community relations for MSMS.

Elder Abuse:

Diagnosis can often be difficult

By Helen Fordham

A tragedy made James G. O'Brien, MD, aware of elder abuse, a tragedy that saw one of his elder patients killed by her son. She was suffocated with a plastic bag shortly after she was released from the hospital where she had been treated for neglect. Nothing was ever proven against the son, but the experience was critical in making Doctor O'Brien aware of elder abuse.

The incident profoundly shocked Doctor O'Brien, who is acting chairman of the Department of Family Practice at Michigan State University. He also is chairman of the AMA's task force established to develop diagnosis and treatment guidelines for elder abuse. "I kept thinking, might there have been something I could have done to affect the outcome? Could I have intervened? Were there clues that I didn't see?" he says.

In trying to find answers to these questions, Doctor O'Brien discovered a lack of research in the field of elder abuse. This prompted him to use a geriatric fellowship he was awarded in 1982-83 to pursue research in the area. As a part of this research he conducted a survey of 3,000 physicians in Michigan and North Carolina. The results indicated that almost 50 percent of physicians had encountered elder abuse recently and that 80 percent of those surveyed were unaware of state reporting laws. However, in order to report abuse it is necessary to know who is at risk and what sort of behavior constitutes elder abuse.

Elder abuse tends to be focused on the frail and the vulnerable, said Doctor O'Brien, and occurs most frequently among the 65 and older age group. It is estimated that four percent of the elderly population are the targets of domestic violence and that only one out of every 13 cases of elder abuse are reported.

Elder abuse defined

Abuse takes many forms, according to Doctor O'Brien, ranging from emotional, physical and sexual abuse to the withholding of food and medicine, theft of property and intimidation. However, much of the abuse is of the less violent type. "The most common type of abuse is neglect," he says, "where the basic needs of an older adult are not being met."

In isolating patterns of abuse it is generally believed that violence is typically perpetrated by family members. Frequently, it is a situation where there is a single

caretaker with a heavy burden of care combined with a demanding and mentally incompetent patient. This is the scenario that usually leads to abuse, says Doctor O'Brien. The caregiver can end up abusing or neglecting the patient because they are simply exhausted and burned out, he says.

Burnout is not the only cause of abuse, however. Violence may be part of the family's cycle of abuse, says Doctor O'Brien. There is plenty of evidence to suggest that those who are abused become abusers. Doctor O'Brien also believes that, as a culture, America is very violent. "There is less value placed on older adults," he says, "because we are still a youth-oriented society."

Diagnosis often tricky

Diagnosing abuse can be difficult, says Doctor O'Brien, partially because of society's ageist attitude. Older adults are often excluded by the family and physician from discussions about their welfare, and their input dismissed. In addition, in making a clinical assessment of older people, they bruise more easily which makes it harder to attribute injuries as abuse, says Doctor O'Brien.

Although it is a legal requirement for physicians to report suspected elder abuse and they can be fined for non-compliance, there are several reasons why physicians may be deterred from doing so. They may be fearful that the family may take legal action against them, says Doctor O'Brien. Also, physicians in the past may also have been frustrated by an elder patient who refused treatment or if there has been no follow up, he added. Doctor O'Brien believes physicians have an ongoing role in preventing elder abuse. Physicians can serve as a monitor over time to ensure that people don't fall back into the patterns of abusive behavior, he says. They can also act as advocates of elder abuse. "There needs to be increased public awareness of this issue," he added, "and more resources to deal with this problem." ■

Helen Fordham is chief of community relations for MSMS.

Summary of Abuse and Neglect Reporting Requirements

CHILD ABUSE

ADULT ABUSE

What must be reported?

Physical abuse, mental abuse, sexual abuse, neglect, sexual exploitation.

Physical abuse, mental abuse, sexual abuse, maltreatment, neglect, exploitation.

Who is required to report?

The law requires it of "mandated reporters" such as physicians, nurses, coroners, medical examiners, dentists, licensed emergency medical care personnel, audiologists, psychologists, family therapists, social workers, school administrators, school teachers/counselors, law enforcement officers and child care providers.

Any person employed, licensed, registered or certified to provide, or an employee of an agency licensed to provide health care, educational, social welfare, mental health or other human services; or a law enforcement officer or an employee of the County medical examiner.

What are the time frames and types of reports that must be made?

Verbal report, immediately written report (DSS-3200) within 72 hours.

Verbal report, immediately. Written report at the discretion of reporting person.

What are the criteria for reporting?

Reasonable cause to suspect.

Suspicion or reasonable cause to suspect or believe.

To whom do I make reports?

Verbal and written report to the Children's Protective Services in the DSS office in the county in which the violation is alleged to have occurred. If reporting person is an employee of an agency, hospital or school, he or she must also report to the chief administrator where he/she works.

Verbal and written report to the Audit Protective Services in the DSS office in the county in which the violation is alleged to have occurred.

Is there a penalty for failure to report?

Yes - Civil liability for damages caused by failure to report. Misdemeanor.

Yes, Civil liability for damages caused by failure to report \$500 civil fine.

Is it necessary to report to multiple agencies?

Yes, in all cases each agency must be contacted regarding an allegation suspected to have occurred which falls under its specific jurisdiction. There are several citations in each law or rule stating that reporting to one agency does not absolve the reporting person of responsibility to report under other existing laws or to other responsible agencies.

Yes, in all cases each agency must be contacted regarding an allegation suspected to have occurred which falls under its specific jurisdiction. There are several citations in each law or rule stating that reporting to one agency does not absolve the reporting person of responsibility to report under other existing laws or to other responsible agencies.

If there is more than one person with knowledge, must all of them report?

You must report or "cause a report to be made." In the case of a school, hospital or agency, one report is adequate.

Yes, must report. There is no provision for "causing a report to be made." However, DSS agencies have typically accepted one report from agencies, not requiring multiple reports.

Are there other agencies to which reports can be made?

Yes. The Michigan Department of Public Health is responsible for investigating abuse and neglect in nursing homes. The Michigan Attorney General's office has an abuse investigation unit which may investigate abuse in nursing homes. Typically, licensing laws under which care facilities are required to operate mandate that the provider must notify the licensing agency when complaints of abuse or neglect are received. For example, Public Health licenses nursing homes, while DSS licenses adult foster care facilities and child care organizations.

Yes. The Michigan Department of Public Health is responsible for investigating abuse and neglect in nursing homes. The Michigan Attorney General's Office has an abuse investigation unit which may investigate abuse in nursing homes. Typically, licensing laws under which care facilities are required to operate mandate that the provider must notify the licensing agency when complaints of abuse or neglect are received. For example, Public Health licenses nursing homes, while DSS license adult foster care facilities and child care organizations.

Reproduced courtesy of the Michigan Department of Mental Health

Domestic violence legislation

Nine-bill package, if passed, would "put teeth" into way assailants are handled

Police officers and prosecutors -- not victims -- should have the burden of pursuing domestic violence complaints. That's if the Legislature intends to treat domestic assault in the same manner as other crimes and reduce its occurrence, victim advocates recently told members of the State Senate Family Law, Criminal Law and Corrections Committee.

The committee has under consideration more than 40 domestic violence bills, including a nine-bill package passed by the House that would "put teeth" into injunctive orders against assailants, encourage arrests in domestic violence situations and increase penalties for subsequent domestic assaults.

Macomb County Prosecutor Carl Marlinga said police and prosecutors answer calls on crimes between strangers with the expectation that a crime occurred, but in domestic disputes they are too doubtful, frustrated by victims not following through, uncomfortable in intervening between spouses and too conviction-oriented to really help the victims.

The most effective way to deter subsequent domestic assaults and encourage victims to help the prosecution, Mr. Marlinga said, is to not allow police to use their discretion against making an arrest if they suspect a crime has been committed; to require police to sign the complaint rather than the victim; to make it clear it is a criminal offense by having the state rather than the individual follow through on charges; and to have the victim serve as a witness, as he or she would do in other criminal prosecutions. "That would show it is not a private family matter but a criminal matter," Marlinga said.

Compared to the over 100,000 domestic violence complaints each year in Michigan, with one-third of those victims suffering injuries requiring medical attention, only about 6,000 actually receive shelter and another 7,200 obtain nonresidential help, such as counseling, according to the Michigan Department of Social Services. ■

Synopsis of Bills in domestic violence package

- 1** *Representative Thomas L. Hickner (D-Bay City) HB 5551*
The Hickner proposal amends the Code of Criminal Procedure to implement a preferred arrest policy in domestic violence situations. Specifically, an officer would be required to arrest an assailant where there is probable cause to believe domestic violence is occurring. However, an officer would be permitted to decide not to arrest a person in the event the officer decided the person was acting in self-defense or was not the primary aggressor.
- 2** *Representative Sharon L. Gire (D-Clinton Township) HB5544*
The Gire proposal amends the Code of Criminal Procedure to prohibit a magistrate from refusing to accept a complaint involving an allegation of domestic violence unless the complaint is signed by the victim. The effect of this would be to permit the signing of complaints by police officers based on "information and belief" which is derived from the statement of the victim.
- 3** *Representative Frank Fitzgerald (R-Grand Ledge) HB 5548*
The Fitzgerald proposal amends the Divorce Act to permit the entry of an injunction, after the filing of a complaint for divorce, prohibiting a spouse from "threatening to kill or seriously physically injure a named person."
- 4** *Representative Barbara Dobb (R-Union Lake) HB 5546*
The Dobb proposal is a companion to #3 and #5 and amends the Revised Judicature Act to allow a person to seek an injunction which includes a prohibition against "threatening to kill or seriously injure a named person."
- 5** *Representative Ken Sikkema (R-Grandville) HB 5549*
The Sikkema proposal is a companion to #3 and #4 and amends the Code of Criminal Procedure to permit a warrantless arrest by a police officer for violation of an injunction which prohibits the accused from "threatening to kill or seriously physically injure a named person."
- 6** *Representative Paul T. Baade (D-Roosevelt Park) HB 5547*
The Baade proposal amends the Code of Criminal Procedure to clarify that the prosecutor shall prosecute criminal contempt proceedings initiated in response to an alleged violation of an abuse injunction.
- 7** *Representative Floyd Clack (D-Flint) HB 5545*
The Clack proposal amends the Code of Criminal Procedure to reduce the number of times a judge may defer a defendant's assault conviction and dismiss the proceeding upon the defendant's fulfillment of certain conditions, from two to one.
- 8** *Representative Perry Bullard (D-Ann Arbor) HB 5536*
The Bullard proposal amends the Marriage Act to increase the marriage license fee from \$20 to \$25 and to require counties to allocate \$5 for contracting with domestic violence shelters to provide legal advocacy for domestic violence victims or to monitor law enforcement response to domestic violence.
- 9** *Representative Tracey A. Yokich (D-St. Clair Shores) HB5562*
The Yokich proposal amends the Penal Code to increase the penalty for subsequent domestic violence assaults.

Millions Victimized by Family Members Every Year!

Are you concerned about the effects of family violence and victimization within your community?

Become an advocate within your community for the prevention of family violence.

Violence among family members has reached staggering proportions. Every year more than 2 million cases of child abuse and neglect are reported, between 2 and 4 million women are battered by their spouses, and between 700,000 and 1.1 million of the elderly population are abused.

The American Medical Association has formed a *National Coalition of Physicians Against Family Violence*. Through the *Coalition* the American Medical Association hopes to involve you in activities that address issues of child abuse, sexual assault, domestic violence and elder abuse because you have the unique ability to identify the symptoms, first-hand. By joining the *National Coalition* you will be showing your concern about the effects of family violence and victimization, and will become a committed advocate within your community for the prevention of family violence.

Through the *Coalition* you will:

- be informed about local contacts and referrals
- become aware of local and regional resources
- be provided with information regarding model educational programs
- become aware of treatment guidelines and protocols.
- have access to newsletters, public education materials and other publications
- receive an official membership card and frameable poster alerting your patients of your interest in and concern for this problem.

The only **cost** to you **is your commitment** to help curb this problem. Simply complete the membership application form below and mail to the Department of Mental Health, American Medical Association, 515 N. State Street, Chicago, IL 60610.

Yes, include my name in the *Coalition's* membership

Name _____

Address _____

City/State/Zip _____ Telephone # _____

Specialty _____

Auxiliary Member ☐ Yes ☐ No

Other _____

Area of interest within Family Violence: ☐ Child Abuse ☐ Sexual Assault ☐ Domestic Violence

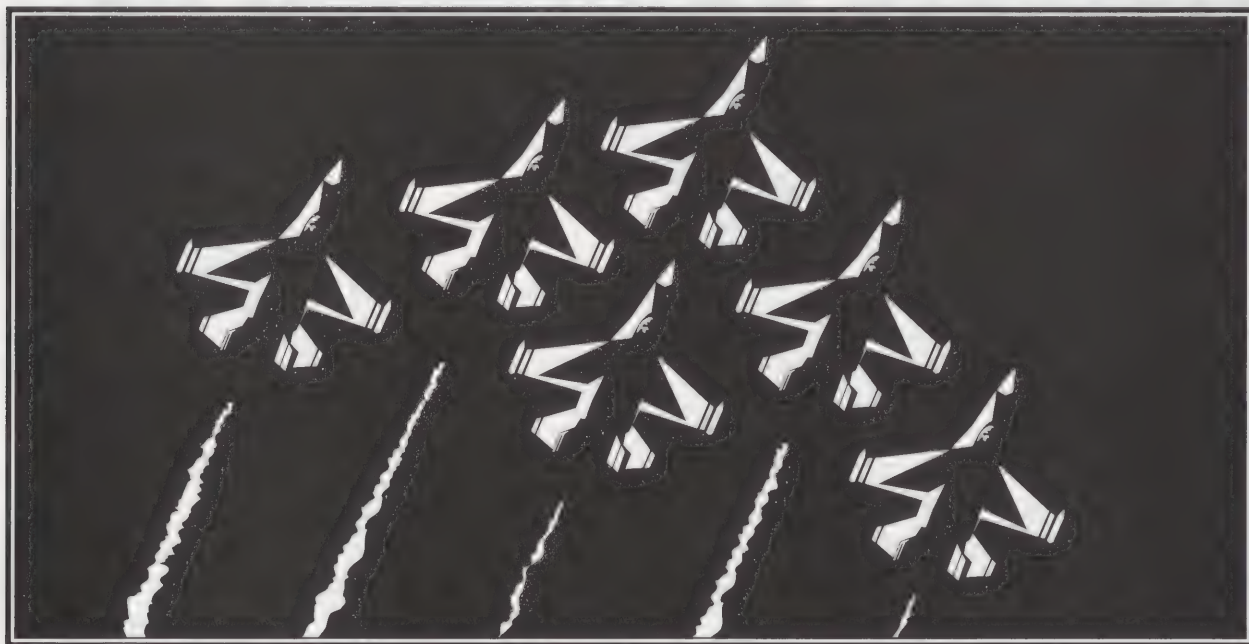
☐ Elder Abuse ☐ Other

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Where victims can go for help

Shelters by County

Editor's note: Shelters offer the following services: Emergency Accommodation for a limited period, counselling and support groups, legal advocacy, child care services and referrals to other community assistance.

ALPENA COUNTY

Shelter, Inc.

P.O. Box 797
Alpena, MI 49707
Contact: Lucy Howard
Telephone:
(517) 356-9650 24 hour crisis line
(517) 356-6265 Business
Provides services to both residents and non-residents.
Serves five counties Alcona, Alpena, Iosco, Montmorency, Presque Isle.

BARAGA COUNTY

Baraga County Shelter Home

11 South Fourth Street
L'Anse, MI 49946
Contact: Charlene Kangas
Telephone:
(906) 524-5017 (Crisis Line)
(906) 524-7078 (Business)

BAY COUNTY

Bay County Women's Center

P.O. Box 1458
Bay City, MI 48707
Contact: Karen Kling
Telephone: (517) 686-4551
Serves Bay and Arenac Counties.

BERRIEN COUNTY

Safe Shelter, Inc.

275 Pipestone
Benton Harbor, MI 49022
Contact: Mable Dunbar
Telephone:
(616) 925-2280 (business)
(616) 983-4275 (crisis line)
Serves three counties - Berrien, Van Buren and Cass.

BRANCH COUNTY

Branch County Coalition Against Domestic Violence also known as Branch County Shelter House

P.O. Box 72
Coldwater, MI 49036
Contact: Shirley Pascal
Telephone: (517) 278-7432
Services include a sexual assault program.

CALHOUN COUNTY

Battle Creek Area Organization/Safe Place Against Domestic Violence

P.O. Box 199
Battle Creek, MI 49016
Contact: Cathy Lucas
Telephone:
(616) 965-7233 (Crisis Line)
(616) 965-6093 (Business)
Residents and non-residents. Serves three counties Calhoun, Berry and Eaton.

CHIPPEWA COUNTY

Eastern Upper Peninsula Domestic Violence Program, Inc.

Also known as the Dianne Peppler Shelter
P.O. Box 636
Sault Ste. Marie, MI 49783
Contact: Doreen Howson
Telephone:
(906) 635-0566 (business/crisis)
1-800-882-1515 Crisis
Service three counties Chippewa, Mackinac and Luce. Provides services for men.

CLARE COUNTY

Women's Aid Service, Inc.

P.O. Box 743
Mt. Pleasant, MI 48804-0743
(mailing address)
Contact: Lynn LaPorte
Telephone:
(517) 773-0078 Business Line
Provide shelter, individual counselling, support groups also offer a men's program for batterers.

CLINTON COUNTY

RAVE

P.O. Box 472
St. Johns, MI 48879
Contact: Kelly Miley
Telephone:
(517) 224-4662 (Business)
(517) 224-7283 (Crisis)

CRAWFORD COUNTY

Mercy Hospital/River House

P.O. Box 661
Grayling, MI 49783
Contact: Ferne Farber
Telephone:
(517) 348-8972 (Crisis Line)
(517) 348-3169 (Business)

DELTA COUNTY

Delta County Alliance Against Violence & Abuse, Inc.

1019 Ludington
Escanaba, MI 49829
Contact: Bev Henrichsen-Berhow
Telephone:
(906) 428-2121 (Crisis Line)
(906) 789-9207 (Business)

DICKINSON COUNTY

The Caring House, Inc.

508 Stanton Street
Iron Mountain, MI 49801
Contact: Susan Gustafson
Telephone:
(906) 774-1112 (Crisis Line)
1-800-232-3226
(906) 774-1337 (Business)
(906)-774-5524 (Sexual Assault Hotline)

EMMET COUNTY

Women's Resource Center of Northern Michigan, Inc.

423 Porter
Petoskey, MI 49770
Contact: Jan Mancinelli
Telephone:
(616) 347-0082 (Crisis Line)
(616) 347-0067 (Business)
(616) 347-0070 (Family Services)

EATON COUNTY

Gateway Community Services Eaton Shelter for Families

240 S. Cochran
Charlotte, MI 48813
Telephone:
(517) 351-4000 (Business)
(517) 543-7350
Contact person: Nancy Oliver
Council Against Domestic Assault
P.O. Box 14149
Lansing, MI 48901
(517) 372-5572

GENESEE COUNTY

YWCA of Greater Flint

310 East Third Street
Flint, MI 48502
Contact: Mary Ann Ketels
Telephone:
(313) 238-7621 ext. 355 (business)
(313) 238-SAFE

GOGEBIC COUNTY

Domestic Violence Escape, Inc.

P.O. Box 366
Ironwood, MI 49938
Contact: Lucia Patritto
Veronica Vuckovic
Telephone:
(906) 932-0310 (Crisis Line)
(906) 932-4990 (Business)

GRAND TRAVERSE COUNTY

Women's Resource Center of the Grand Traverse Area

720 S. Elmwood
Traverse City, MI 49684
Contact: Mary Lee Lord
Telephone: (616) 941-1210 (crisis)

GRATIOT COUNTY

Women's Aid Service, Inc

P.O. box 251
Alma, MI 48801

Continued from page 35

Contact: Lyne LaPort
Telephone: (517) 463-6014

HILLSDALE COUNTY

Domestic Harmony

P.O. Box 231
Hillsdale, MI 49242
Contact: Kristin Lucas
Telephone: (517) 439-1454

HOUGHTON COUNTY

Shelter Home for Abused Women, Inc. also known as the Barbara Kettee Gundlack Shelter for Abused Women.

P.O. Box 8
Calumet, MI 49913
Contact: Emily Newhouse
Telephone:
(906) 337-5623 (Crisis Line)
(906) 337-5632 (Business)

IONIA COUNTY

Eight Cap Domestic Violence, Inc.

P.O. Box 93
Ionia, MI 48846
Contact: Catherine Talburg
Connie Dykes (Shelter Manager)
Telephone:
(616) 527-3351 (Before 4:30 p.m.)
(616) 527-5252 (After 4:30 p.m. and
weekends)

INGHAM COUNTY

Council Against Domestic Assault

P.O. Box 14149
Lansing, MI 48901
Contact: Abby Schwartz
Telephone:
(517) 372-5572 (Crisis Line)
(517) 372-5976 (Business)
Gateway Community Services
910 Abbott Rd, Suite 100
East Lansing, MI 48823
(517) 351-4000 Business
(517) 487-5252
Contact: David Glerum
Provides emergency shelter for runaway
and homeless youth 16-19.

ISABELLA COUNTY

Women's Aid Service, Inc.

P.O. Box 743
Mt. Pleasant, MI 48804-7043
Contact: Muriel Straight
Telephone: (517) 772-9168 (Crisis Line)
(517) 773-0078 (Business)

JACKSON COUNTY

Aware, Inc.

P.O. Box 1526
Jackson, MI 49204
Contact: Dottie Bowersox
Telephone: (517) 783-2671
(517) 783-2861 (Business)

KALAMAZOO COUNTY

YWCA Domestic Assault Program

353 E. Michigan Avenue
Kalamazoo, MI 49007
Contact: Barbara Mills
(616) 385-3587 (Crisis Line)
(616) 385-2869 (Business)
Supplies shelter, counselling community
education

KENT COUNTY

YWCA Domestic Crisis Center

25 Sheldon Boulevard SE
Grand Rapids, MI 49503
Contact: Carla Blinkhorn
Telephone: (616) 459-4652 (before 5:00
p.m.)
(616) 451-2744 (24 hours)

Advisory Center for Teens (The Bridge and Homeless Youth Service)

1115 Ball NE
Grand Rapids, MI 49503
Phone: 616 451 -3001 (24 hour Line)
Contact Person: Intake Worker
Senior Neighbours
50 Weston St S.W.
Grand Rapids, MI 49503
Phone: 616 459-6019 (Business)
Contact: Eunice Thurman
Foster Housing

LENAWEE COUNTY

Catherine Cobb Shelter

213 Toledo Street
Adrian, MI
Contact: Karla Snyder Barker
Telephone: (517) 265-6776

LIVINGSTON COUNTY

Livingston Area Council Against Spouse Abuse, Inc.

P.O. Box 72
Howell, MI 48844
Contact: Joyce Ewing
Telephone: (313) 227-7100 (Crisis Line)
(517) 548-1350 (Business)

MACOMB COUNTY

Michigan Coalition Against Domestic Violence

P.O. Box 463100
Mt. Clemens, MI 48046
Contact: Carol Sullivan
Telephone: (313) 954-1180

MANISTEE COUNTY

Choices

P.O. Box 604
Manistee, MI 49660
Contact: Tracy Swidorski
Telephone: (616) 723-6597 business
(616) 723-6597 crisis line

MARQUETTE COUNTY

Women's Center

1310 South Front Street
Marquette, MI 49855
Contact: Kim Gustafson
Telephone: (906) 225-1346 (business)
(906) 226-6611 (crisis)

MASON COUNTY

Region 4 Community Services

210 N. Harrison Street
Ludington, MI 49431
Contact: Chris Warne
Telephone: (616) 843-2539 (Crisis Line)
(800) 950-5808 (Crisis Line)
(616) 843-2539 (Business)

MECOSTA COUNTY

Women's Information Service, Inc.

P.O. Box 1074
Big Rapids, MI 49307
Contact: Kris Lukens-Rose
Telephone: (616) 796-6600 (Crisis Line)
(616) 796-6692 (Business)

MIDLAND COUNTY

Council on Domestic Violence and Sexual Assault

P.O. Box 2289
Midland, MI 48641
Contact: Barbara Badgero
Telephone: (517) 835-6771

MONROE COUNTY

Family Counseling & Shelter Services of Monroe County

502 W. Elm Avenue #G-East
Monroe, MI 48161
Contact: Sharon Ridella-Mehlos
Telephone: (313) 241-2380

MUSKEGON COUNTY

Every Woman's Place, Inc.

1706 Peck Street
Muskegon, MI 49441
Contact: Mary McDonald
Telephone: (616) 726-4493 (Before 5:00
p.m.)
(616) 773-0078 (After 5:00 p.m. and
weekends)

OAKLAND COUNTY

Haven

P.O. Box 787
Pontiac, MI 48343
Contact: Debi Cain
Telephone: (313) 334-1274 (Crisis Line)
(313) 334-1284 (Business)

OTTAWA

Center for Women in Transition

304 Garden Avenue
Holland, MI 49424
Contact: Carol Rickey
Telephone: (800) 851-4054 (Crisis Line)
(616) 392-2829

SAGINAW COUNTY

Underground Railroad, Inc.

P.O. Box 565
Saginaw, MI 48606
Contact: Joseph Sedlock
Telephone: (517) 755-0411

ST. CLAIR COUNTY

Domestic Assault Rape Elimination Services

1625 Pine Grove Avenue
Port Huron, MI 48060
Contact: Carolyn Superczynski
Telephone: (313) 985-5538 (Crisis Line)
(313) 985-4950 (Business)

ST. JOSEPH COUNTY

St. Joseph County Domestic Assault Shelter Coalition

P.O. Box 402
Three Rivers, MI 49093
Contact: Pat Hillman
Telephone: (800) 828-2023 (Crisis Line for
616 area only)
(616) 279-5122 (Business)

TUSCOLA COUNTY

The Human Development Commission

429 Montague Avenue
Caro, MI 48723
Contact: Karen Kopka
Telephone: (800) 292-3666 (Crisis Line)
(517) 673-4121 (Business)

VAN BUREN COUNTY

Van Cas Cap

488 S. Paw Paw Street
Bow 187
Lawrence, MI 49064
Contact: Linda Kravets
Telephone: (616) 674-3905

WASHTENAW COUNTY

Domestic Violence Project, Inc.

P.O. Box 7052
Ann Arbor, MI 48107
Contact: Susan McGee
Telephone: (313) 995-5444 (Crisis Line)
(313) 973-0242 (Business)

WAYNE COUNTY

First Step

8381 Farmington Road
Westland, MI 48185
Contact: Judy Ellis
Telephone: (313) 525-2230

WEXFORD COUNTY

Cadillac Area O.A.S.I.S.

P.O. Box 955
Cadillac, MI 49601
Contact: Cheryl Bader
Telephone: (616) 775-7233 (Crisis Line)
(616) 775-7299 (Business)

Michigan Physicians join AMA Coalition against domestic violence

Carla Blinkhorn, *Lansing*
Gina Gora, *Okemos*
Elly Hann, DO, *Troy*
Michael Fusillo, MD, *Allegan*
Beverly Jensen, E. *Grand Rapids*
Robert Dixon, Jr., MD, *Grand Haven*
Chuck Heyka, MD, *Petoskey*
Maurice Chapin, MD, *Millington*
Dianne Ansari, MD, *Lansing*
Sohail I. Ahmad, MD, *Port Huron*
Alida Asencio, MD, *Cheboygan*
James W. Brasseur, PAC, *Greenville*
Virginia Caradonna, MD, *Birmingham*
Cynthia S. Lane, MD, *Detroit*
David J. Lieberman, MD, *Monroe*
Frank B. Walker, MD, *St. Clair Shores*
Margaret Thompson, MD, *Grand Rapids*
Deborah L. Webb, *Dearborn*
Steven J. Young, MD, *Kalamazoo*
Joseph P. Zajchowski, *Hamtramck*
Doris A. Suci, MD, *Flint*
Douglas Segal, MD, JD, *East Lansing*
Gale Northcross, MD, *Detroit*
Alvin Michaels, MD, PC, *Bingham Farms*
Edward Pazuchowski, MD, *St. Clair Shores*
Maurice B. Potts, MD, *Detroit*
Barbara Ross-Lee, DO, *East Lansing*
Sara Lawrence-Zako, *Lansing*

More information on domestic violence coming in future issues of Michigan Medicine

Many Michigan physicians are dedicating countless hours to helping treat victims of domestic violence -- either individually or in conjunction with other physicians or social agencies. At least one county medical society already has set a program in motion to help educate physicians and the public about domestic violence.

Highlights of these activities and others will be featured in future issues of *Michigan Medicine* as part of a new series on domestic violence.



"Ron's Rule—I give myself one week to meet new people and start having fun on a locum tenens assignment. It hasn't failed me yet."

Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He wanted to travel. He loves to meet people. A little time off sounded really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

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A salute to WOMEN IN MEDICINE

MSMS takes its hat off to the nine female county medical society presidents

By Helen Fordham and Betty McNerney, Editor

The AMA has declared September "Women in Medicine Month" -- a time to celebrate the great strides made by women physicians. MSMS takes this opportunity to honor the nine women physicians who serve (or have very recently served) as county medical society presidents.

Each woman physician was asked a series of questions about her experiences as a female doctor -- her greatest challenge, influences, goals and successes. They also were asked about why they decided to become an active part of organized medicine and, if they could turn back the hands of time, if they would still choose medicine as their profession. Following are highlights of their interviews.

All but one of these leading women physicians indicated that maintaining a balance between their personal and professional lives was a challenge, in some cases their greatest challenge of all.

"It's difficult," said Cathy O. Blight, MD, president of the Genesee County Medical Society. "You become very good at managing time, setting priorities and following through. You have to learn to say no."

Patricia L. Rehfield, DO, president of the Ot-

tawa County Medical Society, concurred.

"The key is a sense of perspective and a recognition that priorities change. I think it is important to devote quality time to all areas. Time management and a supportive husband have helped me balance a practice, school and three children."

Marjan Mohamadi, MD, immediate past president of the Branch County Medical Society, said her greatest challenge is "fighting Medicare...and Blue Cross." As for balancing her personal and professional life, Doctor Mohamadi said, "I have no personal life. I work 24 hours a day."

Despite the many challenges these women physicians face, all but one said that if they could turn back the hands of time, they would still pursue medicine as a profession.

"Medicine is still a very noble and gratifying profession," said Asuncion Q. Luz, MD, president of Lenawee County Medical Society. "If I can help patients because of my skills and through them also help the community, it gives me a sense of accomplishment."

Victoria L. Mackie, MD, president of the Luce County Medical Society, agreed.

"(The medical profession) is so fulfilling and suits me perfectly. I am in family practice, which I think is the only real medicine left. I get to deal with the patients in their entirety, not just the disease. I evaluate patients in their own environment, which often has a lot to do with why they got sick. I find this intellectually challenging and very gratifying."

Doctor Mohamadi said she would not choose medicine again because of her current frustration with pharmacists. "Everybody believes they have



Doctor Blight



Doctor Hickman



Doctor Luz

the knowledge to be a physician," she said. "When pharmacists are giving advice to patients, (patients) don't need me anymore."

Listening a valued skill

Many of these leading women physicians attributed their success to working hard and taking the time to listen to patients.

"I think women bring skills to medicine that patients value -- namely listening," said Caroline G.M. Scott, MD, immediate past president of the Saginaw County Medical Society.

Doctor Rehfield concurred. "I do a lot of listening and encourage people to ask questions and take care of themselves. I see many women in my practice and they seem to appreciate seeing a female physician."

A little native ability, strong convictions, a hearty constitution and little fear of ridicule or opposition are also key to attaining success, according to Doctor Mackie. "I do what I sincerely feel is right and do unto others as I would have done unto me."

Teachers, family and friends were often cited by these women physicians as those who had great influence on their careers. For Rhoda M. Powsner, MD, president of the Washtenaw County Medical Society, her father and a few professors were the people most influential in her life.

"My father always encouraged me to achieve. He believed in education

and its power to help in getting ahead in life. Also, during school, a few professors encouraged me to supersede sexual stereotyping and focus on a willingness to work. When I work, I don't think about being a woman."

For Linda Stanley, MD, president of the Berrien County Medical Society, an old-fashioned "family doc" she saw as a young child growing up in a small town is the person who had the most influence on her career.

"I had a very idealistic view of the kind of family doctor I wanted to be. Although medicine has changed greatly, I have tried to maintain a personal caring approach and spend time with my patients as (my family doctor) did."

Becoming part of organized medicine is essential to achieving goals, both for patients and physicians, according to these women leaders. Following are just a few of the reasons cited by these women physicians.

"As a medical student I felt organized medicine was an overly powerful, rich, self-interest group that ignored the problems of patients," said Doctor Stanley. "As a practicing physician I quickly discovered that issues such as Medicare and Medicaid reimbursement and skyrocketing malpractice premiums impact directly on health care delivery and health care access, and require a political solution that only an organized group can attempt to accomplish."

Doctor Scott said she chose to become involved in organized medicine because she feels "very strongly that female role models are needed in leadership positions."

Behind every successful physician is an agenda, a set of goals, which provides direction. For Marjorie J. Hickman, MD, president of the Calhoun County Medical Society, it is a desire to "see women physicians given the same opportunities as men."

Doctor Blight said her goal is "to see greater physician involvement in politics and organizational medicine. Physicians need to be more proactive," she said.

For the past six years Doctor Rehfield has played a dual role as a general practitioner and medical director of the Ottawa County Health Department. In addition, she is completing her master's degree in public health at the University of Michigan and intends to move into public health full time. Her ultimate goal: to work for the World Health Organization.

Doctor Powsner also has altruistic goals and hopes to "make this world a better place in which to live." "We must work together to make the world a better place for our children and grandchildren," she said.

Doctor Mackie hopes to "see the state of medicine become more equalized between rural and urban areas." "Pay differentials are insulting and insane," she said. ■

Helen Fordham is chief of community relations for MSMS.



Doctor Mackie



Photo not available.

Doctor Mohamadi



Doctor Powsner



Doctor Rehfield



Doctor Scott



Doctor Stanley

Cathy O. Blight, MD
President, Genesee County

An active member of several professional organizations, Doctor Blight currently serves as senior associate pathologist, Hurley Medical Center, Flint; deputy medical examiner for Genesee County; and director, Renal Diagnostic Program, and associate clinical professor, Department of Pathology, Michigan State University College of Human Medicine. A 1977 graduate of the MSU College of Human Medicine, Doctor Blight serves on the MSMS Board of Directors.

Marjorie J. Hickman, MD
President, Calhoun County

A Battle Creek internist, Doctor Hickman is a member of the staff at Battle Creek Health System. She is a graduate of the University of Michigan Medical School.

Asuncion Q. Luz, MD
President, Lenawee County

An Adrian pediatrician, Doctor Luz currently serves as a pediatric consultant to three Lenawee County organizations: MDT-Child Abuse; Sexual Abuse Task Force; and Adrian Head Start. A 1956 medical graduate of the University of Santo Tomas, Manila, Philippines, Doctor Luz is a member of several professional organiza-

tions including the National Association of Prevention of Child Abuse.

Victoria L. Mackie, MD
President, Luce County

A Newberry family physician, Doctor Mackie is a graduate of the Wayne State University School of Medicine.

Marjan Mohamadi, MD
Immediate Past President, Branch County

A Coldwater internist, Doctor Mohamadi is a graduate of the University of Dominica. In 1990, she served as chief of staff at Coldwater Community Center, Coldwater.

Rhoda M. Powsner, MD
President, Washtenaw County

An Ann Arbor cardiologist, Doctor Powsner has held numerous academic, hospital and staff positions. She currently serves as delegate to the AMA, is chairman of the AMA Women's Caucus, and most recently, was appointed to serve on the AMA Ad Hoc Task Force on Domestic Violence. She is a graduate of the Yale University Medical School, the University of Michigan Law School, and the University of Michigan School of Public Health.

Patricia L. Rehfield, DO
President, Ottawa County

Doctor Rehfield is a private practice family physician in Jamestown. A 1979 graduate of the MSU College of Osteopathic Medicine, Doctor Rehfield also serves as an associate clinical professor at the MSU College of Osteopathic Medicine. In addition, she is a member of the MSMS AIDS Speaker's Bureau, and is a member of the Board of Directors of the Michigan Association of Public Health Physicians.

Caroline G.M. Scott, MD
Immediate Past President, Saginaw County

A Saginaw family physician, Doctor Scott is a 1983 graduate of the MSU College of Human Medicine. Born in Watford, England, Doctor Scott emigrated to Saginaw in 1966. She is the recipient of several awards including "Outstanding Volunteer Physician Educator - Family Practice (1987-88 and 1989-90)" from the MSU College of Human Medicine.

Linda K. Stanley, MD
President, Berrien County

A Niles family physician, Doctor Stanley is a graduate of the Indiana University School of Medicine. She is past chief of staff of Pawating Hospital, Niles. ■

MSMS committee addresses concerns of women physicians

Although the number of women physicians is rapidly increasing, women are not joining organized medicine in the same proportions. The role of the MSMS Committee on Concerns of Women Physicians is to explore the reasons why this is happening, and offer suggestions and support systems that will facilitate the movement of more women physicians into every facet of medicine.

The Committee carries out its goals by sponsoring annual workshops, and a networking luncheon at the MSMS Annual Scientific Meeting. The Committee also provides women physicians as speakers for small groups and as mentors for female medical students and residents, and circulates statistical and other interesting information to raise the awareness of many about the role women physicians already play in organized medicine.

If you're interested in more information or in joining the MSMS Committee on Concerns of Women Physicians, contact Stacy Kohmetscher at MSMS, (517) 336-5755.

Committee on Concerns of Women Physicians

Martha L. Gray, MD, Chairman,
Ann Arbor

Rhoda M. Powsner, MD,
MSMS Board Liaison, *Ann Arbor*

Tama D. Abel, MD, *Ann Arbor*

Leslie B. Aldrich, MD, *Ypsilanti*

Miriam S. Daly, MD, *Albion*

Cassandra M. Klyman, MD,
Bloomfield Hills

Vivian M. Lewis, MD, *Flint*

Janet R. Osuch, MD, *East Lansing*

Conchita D. Riparip, MD, *Saginaw*

Marguerite R. Shearer, MD,
Ann Arbor

Dawn E. Springer, MD, *Mason*

Barbara A. Threatt, MD, *Ann Arbor*

Janice L. Werbinski, MD, *Portage*

Eva L. Youshock, MD, *Rochester Hills*

A special salute to Susan H. Adelman, MD

MSMS also takes the opportunity to salute Susan H. Adelman, MD, who, among many other things, served as the first female president of MSMS in 1990-91. Among her many accomplishments is her recent election to the AMA Council on Medical Service. As with the women county medical society presidents, *Michigan Medicine* recently asked Doctor Adelman a series of questions about her experiences as a female doctor. Following are portions of her responses.



Greatest Challenge: "Trying to do a variety of things as well as possible and maintain an active practice...There are additional responsibilities in being a visible woman because of the requests to speak and participate in women's organizational activities."

Goals: "I am interested in working with the AMA health care reform, which I feel will take place in the next few years. I think we are looking at massive reform of our system. I am very pleased to be elected to the Council, which will provide the opportunity to be in a key role in protecting vital interests and helping to craft the changes we are facing. Health care reform will be sweeping and it is vitally important that those who have studied the issues be involved. It is important that the AMA change from being regarded as an entity that speaks for the narrow interests of physicians to an organization that speaks for the interests of all society. In a statesman-like way we clearly need to be seen as representing the patients' interests."

Balance Between Personal and Professional Life: "I define my life as partitioned between my practice and my medical political activities. I don't allocate much time for any other activities. I am also an artist and previously allocated time

to that area, but in the last several years I made the conscious choice to focus on health care reform."

Success: "My pediatric surgical career was challenging to develop and required both persistence and stubbornness. My medical political career was clearly founded on the fact that I write. I've had a gratifying acceptance of my writing and this writing brought my name forward to the county society, BCBSM and MSMS. My name was out there and well known. I believe that writing has been the key."

Would You Go Into Medicine Again:

"Yes, for the same reason I went into medicine in the first place. I had to make a choice between art school and medicine. I felt whatever I could do in medicine would be worthwhile, while it was not so apparent that art would be worthwhile to anybody but me. Even the most routine tasks in medicine are really important to the people I'm helping. It is a much more substantive legacy. And, if it should come to pass that I have a positive impact on health care reform, then I will be overwhelmingly grateful for the opportunity." ■



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Study of women IMGs revealing

Many have served as role models, teachers, mentors to women US grads

By Margaret D. McNiven, PhD

During physician shortages in the 1960s and 1970s, international medical graduates (IMGs) were eagerly recruited into the US, peaking in 1973 with 7,419 licenses issued by State Medical Boards to IMGs (American Medical Association, 1992). In the 1980s, there was a diminishing number of IMGs entering the US and receiving initial licenses, down to 2,749 in 1989. Likewise, fewer IMGs entered graduate medical education in Michigan (Michigan Council on Graduate Medical Education [MCGME], 1987), or were remaining in the US after completion of training.

Historically, women had greater access to medical education in most other nations. In 1970, women constituted 15 percent of all IMGs practicing in the US, while US-trained women constituted only six percent of all US-trained physicians. IMGs (including Canadian graduates) constituted 27 percent of all MD physicians in Michigan in 1985.

Hence, the professional activities of internationally-trained women have influenced the aggregate description of women physicians' professional activities in the US. Women IMGs were a large proportion of the role models, mentors and teachers of the enlarging pool of US women graduates.

Michigan research

Since 1986, physicians licensed in Michigan have been asked to complete a survey on their practice when renewing their license. This author re-analyzed the 1986 data, expanded by matching with AMA

Table 1
Specialty, Degree and Nation of Training of Women Physicians

Degree	% Primary	% Specialty	n
MD Total	38	62	1,588
^a International — All	^b 42	58	404
- ^a Fully Trained	47	53	
- ^a Trainees	21	79	
^a USA — All	^b 36	64	1,184
- ^a Fully Trained	48	52	
- ^a Trainees	21	79	
^a MD Trainees — All	21	79	

Note: ^a significant difference (Chi Square, $p < .00$) between all trainees' specialties and those fully trained, for both international and US women medical graduates.

^b Chi Square, $p < .00$. There were significantly more women IMGs in primary care than US women physicians, in the aggregate.

data, to create a unique data base on 15,770 physicians, referred to as the Michigan Study Group.

Nation of training

Twenty-nine percent of all women MDs in the Michigan study were IMGs, only slightly reduced from 1971 when 36 percent of all women MDs in the US were IMGs. One quarter (25.4 percent) of all MDs, women and men, in the Michigan study group were trained in international schools. This was comparable with the above 1985 figure that 27 percent of all MD physicians in Michigan trained in an international school along with other studies. The Michigan study group was considered representative of the medical workforce in Michigan, and the US.

The five most frequent nations of training for MDs outside of the US

were India (5.9 percent), the Philippines (3.0 percent), Korea (1.6 percent), Iran (0.9 percent) and Pakistan (0.8 percent). Women and men who trained in international schools were distributed similarly among the nations. Rank ordered from the highest, women were more likely to have trained in India, the Philippines, Korea, with Pakistan and West Germany as equal fourth. Men were more likely to have trained in India, the Philippines, Korea, Iran, with Mexico and Pakistan as equal fifth.

Location

Internationally-trained MDs practice twice as often in metropolitan areas, than do US-trained MDs in the nation. The same metropolitan preference was significantly greater for women IMGs in the

Continued on following page

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"Sexual and Gender Harassment in the Medical Workplace"

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For further information or to register for this conference, contact the MSMS Office of Physician Education at (517) 336-5784.



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Michigan study group, than for US medical graduates. One contributing factor was that a larger proportion of older physicians were in metropolitan settings, and on the average, women IMGs were older.

Age

Women physicians have been more customary in other nations than in the US. Therefore, women IMGs are a greater proportion of older women MD physicians (born before 1946) and earlier medical school graduates (before 1971). They are older and earlier graduates as an artifact of both the earlier large-scale targeted immigration in the 1960s and 1970s, as well as the late date at which US medical schools started enrolling more women in 1970 (McNiven, 1991). There is a significant bipolar distribution according to graduation era, as 60 percent of women IMGs graduated before 1971, and 78 percent of the US women had graduated only after the 1970 equal opportunity policy.

Specialty

Specialty opportunities for all women physicians, IMGs and non-IMGs, have broadened in the past decade. However, 10 years before the Michigan study, A. Goldblatt and P.B. Goldblatt (1976) uncovered a hierarchy of physician status, with US-trained men at the top, US-trained women in the middle, and IMGs in the lowest status specialties. Women IMGs were in lower status specialties than male IMGs, and in different specialties than US-trained women.

Among all women physicians in Michigan, 42 percent of women IMGs were in primary care (Table 1), significantly greater than 36 percent of US-trained women MDs, as recorded previously. Two forces may intersect to exaggerate this

specialty difference among women. First, older physicians are proportionately more in primary care, and international women graduates were older than the US graduates in Michigan. Second, when the fully-trained women doctors are separated from those in graduate medical education ("trainees" in Table 1), the numerically greater proportion of US graduates still in training magnifies the difference. All fully-trained MD women, whether international or US graduates, were in primary care at the same rate. Obversely, MD women from both international and US medical schools in graduate medical education in Michigan in 1986 were training in non-primary specialties at the same rate (79 percent), nearly twice as specialized as their fully-trained colleagues.

Career achievements

The number of women deans of the 127 US medical schools reached a historical maximum of three in 1988, two being IMGs. Perhaps their early training years with a greater proportion of women medical directors, faculty and students influenced their career goals. At the beginning of 1992 there were no women deans in the US.

Conclusion

National and Michigan data disclose overriding similarities between internationally-trained and US-trained women physicians.

The increasing number of US women graduates will make the international graduates less visible, but never any less appreciated by their patients and colleagues. ■

[References available upon request.]

Doctor McNiven is consultant to the dean, Wayne State University School of Medicine, Detroit; and principal investigator, Cross National Collaborative Project on Women Doctors in Australia, New Zealand and the US.

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MSMS Liaison Committee with BCBSM

Sets Priorities for the Months Ahead

By Gary D. Maynard, MD

Throughout the past year, we have reported on several MSMS activities and accomplishments affecting relations between Michigan physicians and Blue Cross Blue Shield of Michigan. As fall begins, we are preparing to pursue further changes through legislative activity, the BCBSM Physician Contract Advisory Committee and the MSMS Liaison Committee with BCBSM. Our Task Force on the BCBSM Medical Doctors Provider Class Plan will continue to develop physician recommendations related to the Blues' role in meeting statutory goals health care quality, access and costs. This article reports on some of our priorities in the months ahead.

In May, MSMS testified before a special legislative committee on BCBSM, chaired by State Representative Mary C. Brown. The committee is examining the Blues' enabling statute, PA 350 of 1980 and recommending needed changes. Earlier this year, Representative Brown met with the MSMS Liaison Committee with BCBSM to discuss her priorities in this important area. Although she may not agree with all of our concerns, the Liaison Committee found many areas of mutual interest. In particular, Representative Brown and her Committee are interested in changes to the appeals process used to resolve disputes with BCBSM. The Committee also is interested in exploring means for having the Blues assume a more proactive role in assuring quality and access for its subscribers.



Gary D. Maynard, MD

Appeals process a key issue

The need for a fair and reasonable appeals process has been a central issue in ongoing litigation related to the Blues' 1987-88 Medical Doctors' Provider Class Plan and the 1990 Physicians and Professional Providers Participating Agreement. Late in 1991, MSMS convened a Task Force on the BCBSM Provider Class Plan to develop recommendations for changes to the plan. Eight physicians serve on the Task Force, including four representatives from the MSMS Liaison Committee with BCBSM and four physicians who were petitioners or supporters in the litigation. Detroit attorneys Andrew B. Wachler and Gilbert M. Primet have served as consultants to the Task Force, along with MSMS staff and legal counsel. The first priority of the Task Force was the development of a fairer, faster appeals process, and the Task Force's recommendations have recently

been approved by the MSMS Board of Directors.

Under our new recommendations for an appeals process, a physician's right to appeal BCBSM decisions would be broadly applied to audits, medical policy issues, reimbursement, coverage issues (including coverage for procedures previously considered new or investigational), departicipation, medical necessity decisions and pre-payment utilization review. Strict time frames are included to assure that appeals are handled expeditiously. A three-step process, including an informal conference, a regional mediation panel and binding arbitration or court would be available for appeals on all issues.

The Task Force's recommendations were developed to improve the ability of physicians and BCBSM to resolve disputes at the earliest possible stage in the appeals process and to enhance the educational value of the process in issues involving medical judgments. The Task Force is recommending that the informal managerial conference be conducted with disclosure of issues under dispute and participants in the conference. Under our recommendations, BCBSM would be required to assure that their representatives in the process have the ability and the authority to make and implement a decision.

The regional mediation step would be conducted by physicians. To the extent practicable, the me-

diators would be of the same specialty and region as the physician bringing the appeal. This step would be optional, except in cases involving medical necessity or new and investigational procedures. In these instances, the Task Force believed that the educational value of this process is too valuable to bypass. The regional mediation process would not be binding.

The final step in the process would be an appeal through binding arbitration, the courts or the Insurance Commissioner. In the arbitration process, physicians would serve on the arbitration panels.

MSMS will be sharing these new recommendations with the legislature and with the Physician Contract Advisory Committee. The special committee on BCBSM will be releasing recommendations this fall, and we hope our appeals process and measures to address many other concerns will be included in those recommendations. In the meantime, we will continue our efforts through the BCBSM Physician Contract Advisory Committee to seek a fairer, faster appeals process. The Physician Contract Advisory Committee includes five MSMS representatives, three representatives of the Michigan Association of Osteopathic Physicians and Surgeons and eight members of the BCBSM Board of Directors.

Our recommendations for a streamlined appeals process rely heavily on input from physicians. An effort to improve the involvement of practicing physicians in existing BCBSM programs and policies will culminate this fall, when BCBSM begins using physicians recommended by our specialty societies as reviewers and consultants in many areas of activity.

Payment levels another concern

Blue Cross Blue Shield of Michigan payment levels are another area of concern for Michigan physicians. Discussions in the BCBSM Physi-

cian Contract Advisory Committee generated BCBSM recommendations for an increase in physician payments. Blues' payments to physicians for most services increased by five percent statewide. In southeastern Michigan, an additional 2.5 percent increase was implemented to achieve the goal of a single statewide fee schedule. The increases were implemented April 1.

Unfortunately, the BCBSM recommendations excluded pathology and diagnostic radiology services from the increases. A priority for MSMS in the coming months will be further examination of the Blues' rationale for these exclusions and efforts to achieve equitable payment for those services.

Payment levels for new E&M codes a priority

Another priority in the months ahead will be payment levels for the new evaluation and management codes. Discussion at the MSMS Liaison Committee with BCBSM and the BCBSM Physician Contract Advisory Committee highlighted members' concern about reimbursement for these new codes. A subcommittee of the Liaison Committee is now working with BCBSM staff to reevaluate the Blues' relative value units for evaluation and management services.

Several years ago, BCBSM commissioned a study to determine how payment in Michigan compares with payment in other states. Although there are many questions about the methodology of the study, the results are still alarming: payment for services in Michigan is about 40 percent less than the average of payments from Blues plans in five neighboring states. Some have argued that these differences are justified by corresponding differences in use patterns and that they are mitigated by increases in payment in Michigan over the last few years. Through the BCBSM Physi-

Continued on following page

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sician Contract Advisory Committee, we have agreed to reexamine the differences between payment and use in Michigan and in neighboring states.

Independent researchers from the University of Michigan School of Public Health have begun to work with data from Michigan and five comparable Blues plans to produce a comparison of payment levels for selected services and a comparison of use of services that is adjusted for age and gender. MSMS plans to use the information gathered in that study to support improvements in payment and to seek further examination of factors that affect use of services. These factors might include health status, medical liability and scope of benefits. MSMS has been working for a year to initiate this study and we look forward to its completion in December.

Improvements encouraging

The Liaison Committee with BCBSM has been encouraged by improvements in service from BCBSM, as evidenced by our January, 1992 survey about the Provider Inquiry Department, the expansion of systems to speed verification of eligibility and benefits, the creation of dedicated telephone lines for each of the state's four area codes and the development of a new manual for physicians and medical assistants. We will continue to monitor service improvements and identify areas where further work is needed.

One of these areas will relate to the Blues' performance as the intermediary for the Medicare program. At the recommendation of a Liaison Committee subcommittee on Medicare, chaired by Willard Stawski, MD, MSMS is conducting a survey of members to solicit their

experience with service and communications related to Medicare business. A similar survey will be conducted by the Health Care Financing Administration later this year. MSMS plans to use the information gathered from the survey to pursue improvements from BCBSM and to communicate with federal officials about problems and potential solutions.

The MSMS Liaison Committee with BCBSM, our representatives to the BCBSM Physician Contract Advisory Committee and the MSMS Task Force on the BCBSM Provider Class Plan all contribute to our work to improve the Blues' service, policies and payment. The contributions of MSMS representatives Robert W. Black, MD, and Willard S. Stawski, MD, as members of the BCBSM Board of Directors also are vital to our efforts. The collective efforts of these committees, task forces and individuals have resulted in needed changes and identified potential solutions to complex problems. In addition to some of the ongoing issues discussed in this article, MSMS representatives will be busy responding to proposals for new kinds of managed care programs being developed for BCBSM customers. We will be reacting to "cost containment" initiatives and suggesting alternatives that emphasize value and quality. We will continue to help individual members with their claims, policy and payment problems.

As always, I encourage members to contact MSMS with problems or concerns about BCBSM and to watch future issues of *Michigan Medicine* and *Medigram* for updates on these important activities. ■

Doctor Maynard is chairman of the MSMS Liaison Committee with Blue Cross and Blue Shield of Michigan.

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DATA AND TRENDS AFFECTING MICHIGAN
PHYSICIANS from the MSMS Department of
Medical Economics and Health Care Delivery



The Administrative Burden of Third Party Billing Requirements

Like all technological advances, the information explosion has tradeoffs. Computerization allows us to assemble and process more information faster than ever before. But like other advances, the technology of the information age has gotten ahead of itself. The fact that large amounts of information can be gathered means that it must happen, without regards to the cost or merits of doing so. Another drawback is that different entities are progressing into the information age at different rates, leaving gaps between systems that are similar but still different.

One of these gaps exists between third party payers that physicians bill for payment of services. Between government programs, commercial carriers and managed care plans, the number of systems physicians must deal with is growing, and some physicians feel they are falling into that gap without a net. Physicians and their staffs are under relentless pressure to keep up with the requirements and changes in billing. The expense of complying with many different payment rules and paperwork requirements is adding to the cost of health care without improving the actual health of patients. Many physicians are in agreement that administrative costs are too high and that the burden of complying delivers insufficient value for the money spent. Regardless of the fate of any of the current health reform plans, no plan can be truly efficient without dealing with the "hassle factor" of getting paid. At issue is the best way of reducing those administrative costs.

A study published in the *New England Journal of Medicine*¹ attempted to compare the administrative costs of delivering health care in the US versus Canada. Although the finer points of the methodology have been questioned, the findings are still startling: administrative costs may be as much as 117 percent higher in the US. Also striking is the nearly 400 percent increase in health care administrators between 1970 and 1987, versus an approximately 50 percent increase in physicians. A less scientific but more graphic depiction of the paperwork problem was described by a retired pediatrician. In closing his practice, he disposed of 60 pounds and 11,000 pages of rules and regulations from insurance companies and the government.²

In an effort to define the physicians' perspectives on the problem and what potential solutions they envision, physicians and their staffs were interviewed in a variety of practice sizes and specialties. Names have been changed in order to encourage candor, but the practice descriptions are accurate.

General Surgery Solo Practitioner

Doctor Manual is a general surgeon in solo practice on the west side of the state. His office is maintained by a full time receptionist/biller and his wife, who does some of the third party billing as well. Doctor Manual does all of his own coding, writes necessary documentation letters, and attends hearings about three or four times a year to appeal decisions. He becomes very animated when discussing billing problems, because even in his very simple practice arrangement the burden is significant.

For Doctor Manual, the problem is best exemplified by the number of books and manuals he must consult in order to correctly bill the insurance companies. He deals with Medicare, Medicaid, Workers Compensation, Blue Cross Blue Shield of Michigan (both regular business and the managed care system), CHAMPUS, and a multitude of commercial insurers. Each has a large binder containing the rules of billing the program. There are also directories with physician identification numbers, books to identify the appropriate billing code, and newsletters to document changes to the rule manuals. There are also books put out by various specialty and consulting groups that assist the physician in understanding all of the payment systems. If he stacked all of these manuals and publications up, the pile would be over six feet tall.

All of these books have nothing to do with treating the patient, they only answer how to get paid for treating the patient. Even after consulting all of this material, the claims are sometimes rejected. For a complicated case that is billed to Medicare, he can consult the Medicare material, submit the bill, and then face an appeals process that requires more documentation and paperwork. Medicaid instructions are inscrutable, according to Doctor Manual, and they alone have 950 codes to indicate reasons why a bill was rejected.

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Doctor Manual would like to see a uniform claim form, uniform physician identifiers for all of the many Blue Cross programs, and uniform reporting and documentation systems so that he does not have to consult a different manual for every program.

Cardiology Group Practice

This group is located in the mid-Michigan area and consists of 17 cardiologists and 16 people to process claims, as well as nursing and reception staff. The physicians participate with Medicare. Billing costs are 6-7 percent of net collections, which works out to about \$750,000 a year, or \$40,000 per physician. The group's financial administrator cited the number of different billing forms, the variety of regulations and billing methodologies and the duplication of knowledge required as the most burdensome aspects of third party billing. They use a computerized billing service in the Detroit metropolitan area to process their claims and post payments. Particularly burdensome on a cardiology group is the need to file individual claims for small procedures that are done frequently, such as rhythm strips which are billed 1,000 to 2,000 times each month. They bill \$25 per service, are paid \$12-\$13 for each claim, and their cost per bill is \$5-\$10, leaving just a few dollars for each claim. The administrator suggested that there should be a different procedure for billing small services like these that are billed at an extremely high volume.

The administrator cited two expenditures of time that make the billing process so cumbersome. The first is the time it takes to gather the necessary information to bill correctly, and the second is the time that is spent trying to get fair payment. Submitting the claim seems to be only the beginning of the process in many cases, and the additional documentation that is required and time spent filing an appeal or getting a hearing adds to the burden of collecting payment. New procedures are particularly difficult to get paid. Generally Medicare sets payment for a new procedure very low, and Blue Cross follows Medicare's lead, so the practice has to fight to get what it feels is a more reasonable payment from Medicare. The cardiology practice also feels it took a rather arbitrary hit when payment for the interpretation of EKGs was eliminated in the new Medicare rules. This practice has contracted with area hospitals based on time, rather than a per service charge, but it is getting paid much less than before the rule change.

Radiology Group Practice

This radiology practice has 10 physicians and 12 people to process claims. It is located in the mid-Michigan area. The billing administrator shared a typical payment voucher, which describes the claims processed with a particular payment. The practice uses an electronic billing service, and have also participated in Blue Cross's dial-in eligibility service (DENIS) which allows the practice to determine coverage for their patients.

The administrator said that half of the effort of dealing with third party payers comes from problem issues, not from the actual billing itself (although this office was one of the most sophisticated and specialized in terms of employees, so their perspective may not be shared by other practices). They consider coordination of benefits between Medicare and a secondary payer to be a big issue. In some cases the claim will ping-pong between the two payers, each claiming that the other should pay, and the burden is often put on the patient to sort it out. Different systems for preauthorizations or preadmissions require additional paperwork. Many patients do not understand their coverage or the carrier's rules, and Medicare is the most misunderstood system of all. The major complaint is that the program is too complicated, both for patients and for physicians. Sometimes the office cannot get paid for a claim, and other times the insurer sends too much money, which then has to be refunded. In many cases, problems are left to the patient or the physician to solve.

Since this practice submits electronically, the differences between claim forms are handled through computer programming. However, the vouchers that are returned from each third party payer are all different. One of the billers stated that they only keep a few vouchers on file and that they would need a warehouse to keep all the different vouchers commercial insurers use. This means that personnel must spend time posting payments to patient accounts from many different forms, each with their own information and layout.

Overall, the practice administrator feels that if all payers had the same rules, used the same codes and modifiers in the same way, and used the same vouchers, the time and money wasted in processing claims and making appeals would be reduced significantly. ■

¹ Wodhandler, S, Himmelstein, D. The Deteriorating Administrative Efficiency of the U. S. Health Care System. *New England Journal of Medicine*. 2 May 1991: 1253-7.

² Bauer, Alfred W. I'm Finally Putting Third-Party Paperwork Where It Belongs. *Medical Economics*. 18 May 1992: 157-161.

For further details on trends and sources of information, please contact Julie Lester at MSMS.

MSMS Reimbursement Roundup

By Joyce Nurenberg

MSMS REIMBURSEMENT OMBUDSMAN



Reimbursement Roundup addresses third party payer reimbursement issues affecting physician practices. Comments and problems brought to the attention of the Reimbursement Ombudsman are routinely shared with the Liaison Committee with Blue Cross and Blue Shield and its Subcommittee on Medicare Carrier Problems.

The Response File: A Must for Electronic Billers

Physicians submitting claims electronically have a quick source of information about their status -- the response file.

The response file is a report that can be accessed weekly. It contains a status of claims submitted by 8:00 am on Thursday of the previous week. In most instances, the response file showing the status of these accounts is available after seven days. It reports payments, non-payments, front-end reject edits and pend edits. The codes to describe which action has taken place are assigned by BCBSM. However, each individual vendor controls the organization of the report.

The response file from BCBSM will contain responses to claims submitted electronically as well as those submitted hardcopy; Medicare will return an account of claims submitted electronically only. The status of Federal Employee Program (FEP) claims and Medicaid claims submitted electronically is accessed via the response file as well.

The response file is the *only* source of notification that the

claims did not reach the claim processing system, (i.e. those that receive a front-end reject edit). Examples of such claims would be those rejected for missing or incorrect information. These claims will not appear on your paper voucher. If you call Provider Inquiry, they will inform you that they show no record of the claim. This can appear as if your claims are being lost, when in fact notice of the rejections appeared on the response file the week after they were transmitted.

Those claims that are affected by a front-end reject edit should be reviewed for proper resubmission. If you find no error in how your claim was prepared, you should contact the Electronic Data Interchange Department (EDI) at 313-486-2445 with your biller location code. They will then be able to direct you further, if necessary. Once a claim receives a pend edit, it will not reappear on a response file until a final determination has been made.

How to access and how to interpret the response file report information will vary by vendor.

The response file is a great asset to electronic billers, so check with your office staff and be sure that they have the facts on how to utilize this report.

Reimbursement for multiple area radiation treatments allowed

Medicare will allow reimbursement for multiple area radiation treatments when adequately documented. It is necessary to bill line-by-line and submit documentation

to support separate treatment areas and the need for two separate services on the same day of treatment.

When a patient's signature is required

When a service is "medically unnecessary" and it can be shown that the physician knew or could have reasonably been expected to know that the services were not reasonable or necessary, the patient's prior signature is required to hold the patient responsible for payment. According to the Medicare Carrier Manual, medically unnecessary services are those that could be considered investigational or experimental, inappropriate for treatment of the patient's diagnosis, furnished primarily for the convenience of the patient or services rendered at a level above what is needed to safely and effectively treat the patient.

It is not necessary to have a signed waiver for services that are excluded from coverage by the Medicare program. It is the patient's responsibility to know what is covered, although it is good office practice to inform the patient of non-covered services prior to rendering the service. An example of uncovered services includes routine annual exams defined as examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury. Other exclu-

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REIMBURSEMENT ROUNDUP

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sions can be found in the Physicians Medicare Manual or by contacting provider inquiry.

Reimbursement update for procedure X5512

The July 15 issue of *The Record*, (page 3), reported a reimbursement of \$29 for procedure X5512 Closure of lacrimal punctum with a collagen plug, bilateral.

The reimbursement was incorrect. The reimbursement for the bilateral procedure is \$110 and unilateral is \$60. The cost of the plug is included.

When using a silicone plug, it is necessary to bill the "Not otherwise classified" (NOC) code 68999 and to submit a receipt for the cost of the silicone plug(s).

HCFA defines a group and revises the new patient definition

A group practice is defined as one that involves physicians of the same specialty and commonly identified as belonging to a group (i.e., for purposes of payment the group is the payee to patients, Medicare and other insurers. The billing numbers need not be the same to be considered a group practice).

HCFA considers a patient "new" to a physician if the patient has not been seen by another member of the group who is in the same specialty in the prior three-year period. ■



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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

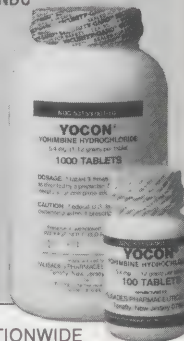
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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CASH-CRASH

Letting cut-rate liability premiums drive your insurance-buying decision can wreck your career and your family's security

By Thomas R. Berglund, MD

Price is an important factor influencing a physician's choice of liability insurer. In fact, some physicians risk their practice and their family's security to get the lowest rate on the market.

Many physicians have been burned by cut-rate insurers that rapidly run themselves into the ground or take the premiums and run.

When you compare prices, be suspicious of premiums that are substantially below prevailing rates.

Price shouldn't be the pivotal factor in buying liability insurance. Typically, it's not the only factor in your decision to purchase a car, a house, a dishwasher, a refrigerator, or dog food. Quality, function, safety, and durability may have priority. Perceived savings in a "bargain" can turn a purchase into a disaster if the product is defective or useless. For physicians who end up with unpaid claims costs, it's even worse.

Before you purchase insurance or change insurers, consider the following:

■ Several "alternative" insurers have failed.

In each of the past three years, at least one major insolvency has been reported among alternative entities offering medical liability insurance. By contrast, the 41 members of the Physician Insurers Association of America (PIAA) generally report excellent financial health. Since 1977 when the PIAA was formed, only one of its members suffered insolvency (a Florida-based company in 1984).

Many alternative insurers aren't subject to state regulation, including minimum reserves and surplus requirements. Since 1986, the federal Risk Retention Act has allowed alternative insurers to be formed and to operate free of most state regulation. Passed under duress of an insurance crisis, the legislation made lower cost insurance available. Since that time, the legislation has proved to be a two-edged sword. While many viable insurance entities have been formed under the federal law, it also has allowed financially weak insurers to continue to operate with insufficient oversight. As a result, several have suffered insolvency. This has led to a groundswell for financial regulation of alternative insurers.

In addition to skirting tough state capitalization standards, alternative insurers do not contribute to state guaranty funds, which cover claims of insolvent insurers. Whenever any type of insurer goes bust, policyholders are exposed to liability claims and costs. But policyholders of traditional insurers are provided some protection by the state guaranty fund.

Here are some details of three reported alternative insurer insolvencies in the past three years:

- * In 1990, the SouthWestern Indemnity and Casualty Insurance Co., based in Arizona, was declared insolvent. At least one former SouthWestern policyholder then joined Michigan Physicians Mutual.
- * In 1991, Louisiana-based Physicians National RRG was placed in liquidation. Tail coverage was unavailable to its policyholders. Again, several of its former policyholders joined Michigan Physicians. At its high point, Physicians National insured about 4,500 physicians.
- * In July, 1992, Tennessee-based United Physicians Insurance RRG was placed in liquidation. It had 2,200 insureds, with about \$15 million in assets and \$28 million in liabilities. According to reports, the RRG experienced financial difficulties because it insured high-risk physicians and its premiums were as much as 70 percent below market.

■ **More failures of weak insurers expected.** Analysts are predicting that many property/casualty insurance companies will suffer insolvency this year. One analyst from Hartford-based Conning & Co. predicted 50 insolvencies by the end of the year. The problem is caused in part by declining investment income due to drops in stock market and real estate values. Insurance company executives continue to stress the need for property/casualty insurers to build financial strength.

In this period of strained financial markets, physicians should cautiously choose a financially strong insurer.

■ **There are scams out there.** In addition, fraud and illegal activity are increasing. Low premiums are typically the lure. One recent example involved Anchorage Fire &



Thomas R. Berglund, MD

Casualty Insurance Co., based in the Turks & Caicos Islands. The company allegedly solicited group health and medical malpractice business illegally in the US. In another recent case, a bogus insurer operating under two separate names solicited premiums from physicians in 10 states then disappeared.

The California Department of Insurance is investigating the finances of five off-shore insurers, including one that filed a phony audit opinion from a Big-6 accounting firm.

Further, Vermont — domicile to 40 percent of all risk retention groups — recognizes the need for increased oversight. It recently added several people to its Insurance Department staff to monitor and oversee captive insurers. Vermont-based alternative insurers have flourished — from 25 in 1986, with an annual premium tax of \$250,000 to more than 200 with an annual premium tax of about \$7 million.

■ **Review an insurer's track record before buying.** In choosing a professional liability insurer, consider a company's experience and history.

Since many alternative insurers were created in and after 1986, their

financial viability is relatively untested. With "long-tail" products like medical liability insurance, claims are typically reported many years after an alleged incident. In the first few years, premiums and assets are growing while claims activity is low. This is the honeymoon period. Premium income exceeds claims payouts by a wide margin. At this point, a favorable balance sheet can be misleading.

Michigan Physicians Mutual has successfully weathered 16 years in Michigan's unpredictable and unfavorable medical liability market. We know first-hand that external factors such as case law, the political environment, and the social sentiment can pose severe problems. Our company has survived two critical crisis periods. We've learned from our experience -- and gained financial strength. Endorsed by the Michigan State Medical Society, our company is the state's only policyholder-owned medical liability insurer and the only one with an all-physician board of directors. We've maintained strong ties to the medical community since we began operations in 1976.

■ **More than ever, purchasing decisions require caution.** At a time when insurance company failures are increasing, unregulated alternative insurers are battling for market share, and scams are multiplying, physicians should be cautious about purchasing liability insurance. A hasty decision to buy cut-rate insurance could cost more than you bargained for.

Shop for value, not price. A low-priced policy is wasted money if the company that sold it disappears or can't pay its bills. And you still face uncovered claims and liabilities. ■

Doctor Berglund is president and chairman of the board of Michigan Physicians Mutual Liability Company.

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Medicare Senior Courtesy Card Programs

Nine Michigan counties have them,
more are in the works

By James G. O'Brien, MD

At the 1992 MSMS House of Delegates Meeting, delegates unanimously passed a resolution of commendation honoring county medical societies and senior citizen organizations for implementing Medicare Voluntary Assignment Programs in Michigan.

With the beginning of Medicare, the MSMS Committee on Aging initiated a monitoring of this "Senior Citizen Health Insurance Plan." This caused Michigan physicians to adopt Resolution 29-85A, "Different Levels of Medicare Reimbursement," at the 1985 House of Delegates Meeting and Resolution 8-88A, "Per Case Assignment of Medicare Payment for the Financially Needy," at the 1988 Meeting, which essentially directed that the Michigan State Medical Society Committee on Aging investigate programs in Michigan counties and other states for per case assignment of Medicare benefits for the financially-needy senior citizens. The resolutions also called upon MSMS, after investigation, to develop a demonstration project and report on the merits of this project to the House of Delegates.

The MSMS Committee on Aging determined that the Michigan physicians had a Medicare assignment rate based on covered charges of 94 percent, approximately 22 percent higher than the national assignment rate. However, it was believed that there is a population of financially needy Medicare-aged persons who would benefit from an organized Voluntary Assignment Program.

In the Spring of 1988, the Midland County Medical Society obtained the endorsement and agreement of its members to participate with the Midland County Council on Aging, the Midland Medical Center's Geriatric Institute and MSMS to organize, develop and implement a Midland Physicians' Senior Courtesy Card Program. An important goal of the county society was accomplished by obtaining the participation of all Midland physicians treating Medicare-aged patients.

Criteria for participation in the Senior Courtesy Card Program required applicants to (1) be aged 65 or older; (2) live in Midland County; (3) participate in Medicare Part-B; and (4) have an annual income of less than two times poverty level as established by the Federal Department of Health and Human Services. (In 1992, the poverty level for a single person is \$6,532 and for a married couple is \$8,238.)

Within the first year of operation, the program had enrolled approximately half of the total number of

“These Senior Courtesy Card Programs represent significant dedication and effort by MSMS physicians, participating county medical societies, and the board administrators and volunteers of the senior citizen organizations in recognizing the needs of low-income senior citizens.”

estimated financially-needy elderly people as determined by the Midland County Council on Aging. The ongoing evaluations of the program begun in early 1990 have continued to be over-whelmingly positive from both patients and physicians. There have been no negative comments.

With this overwhelming success, the MSMS Committee on Aging and the MSMS Physician Hospital Relations Staff assisted in the organization of seven additional programs. The most recent became operational in the summer of 1992, which was the cooperative effort between the Saginaw County Medical Society and the Saginaw County Commission on Aging.

Susan Hershberg Adelman, MD, 1991 MSMS president, awarded Robert S. Brown, MD, Jay Christopher Hough, MD, and Estelle Weismiller, MPH, executive director, Midland County Council on Aging, with the Presidential Citation for their noteworthy and meritorious efforts in creating this program of significant benefit to the financially-needy senior citizens in Midland County. Doctors Brown, Hough and Weismiller are the three principals who generated the original idea and coordinated the efforts of many persons to bring the Midland Senior Courtesy Card Program into being.

Nine counties have programs

The nine County Medical Societies which have Medicare Senior Courtesy Card Programs in operation are:

- Midland County Medical Society
- Gladwin County Medical Society
- Kalamazoo Academy of Medicine
- Calhoun County Medical Society
- Northern Michigan Counties Medical Society
- Delta County Medical Society
- Oakland County Medical Society
- Muskegon County Medical Society
- Saginaw County Medical Society

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Three programs in the works

Three additional County Medical Societies are in the final stages of program organization and are expected to become operational during 1992. These are the Macomb County Medical Society, Grand Traverse/Leelanau/Benzie Counties Medical Society and the Kent County Medical Society.

Twenty-four senior citizen organizations have joined in partnership with county medical societies to operate the Senior Courtesy Card Programs. They are: Midland County Council on Aging; Senior Services, Inc.; Kalamazoo; Albion Community Hospital; Battle Creek Health System; Oaklawn Hospital; Menominee, Delta and Schoolcraft Counties Community Action Agency; Upper

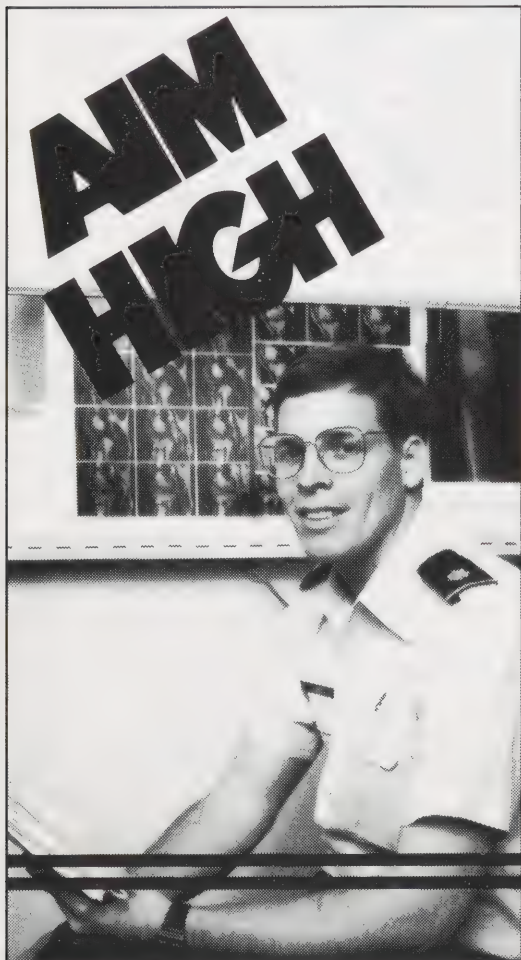
Peninsula Commission for Aging Programs;

Oakland County Medical Society; Senior Citizens Advisory Council; Senior Citizens Providers Forum; Love, Inc., Muskegon; Gladwin Area Hospital; Alpena Senior Citizens Center; Alcona County Commission on Aging; Cheboygan County Council on Aging; Crawford County Commission on Aging; Friendship Centers-Petoskey; Luce County Community Action; Mackinaw County Community Action; Montmorency County Commission on Aging; Northwest Senior Resources, Inc.; Oscoda County Council of Aging; Otsego County Commission on Aging; Presque Isle County Council on Aging; Onaway Senior Center; Posen Center; Sewell Avery Community Center; and Saginaw County Commission on Aging.

These Senior Courtesy Card Programs represent significant dedication and effort by MSMS physicians participating as county medical societies, and the board administrators and volunteers of the senior citizen organizations in recognizing the needs of low-income senior citizens.

Several other county medical societies and seniors' organizations are considering the possibility of establishing Senior Courtesy Card Programs. It is hoped that many more senior citizen organizations will be willing to create a partnership with county medical society physicians having a strong interest in assuring care to financially-needy senior citizens. ■

Doctor O'Brien is chairman of the MSMS Committee on Aging.



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SPECIAL REPORT

PART ONE



'92 Political Candidates

The following is part one of a two-part special report on the 1992 Election Campaign. Included in part one is a detailed report on the activities of the Michigan Doctors Political Action Committee. Also included is a description of what MDPAC is and how it conducts candidate interviews. Immediately following are comments from two of the candidates MDPAC members recently interviewed. Rounding out part one is a rundown of the races to watch. More information on the candidates and those MDPAC supports will be featured in next month's issue of *Michigan Medicine*.

MDPAC: Quizzing the Candidates on Physician Issues

By Ralph D. Ward

The political furor we see this autumn of an election year reminds us of a basic truth of modern society. No professional group or trade can afford to be apolitical anymore. The pervasiveness of government regulation, particularly in the medical profession, means that we either ignore the political process -- and allow our lives to be regulated without our input -- or try to have a positive influence on political decisions.

A major force in making Michigan physicians part of the political game has been the Michigan Doctors Political Action Committee (MDPAC). An organization separate from MSMS for legal reasons, MDPAC is managed by a 30-member board of physicians and MSMS auxiliaries. This direction by members of the physician

community is at the heart of MDPAC, according to MSMS Chief of Political Affairs Sandra Bitonti. "Health care is absolutely the biggest legislative issue right now. MDPAC contributes to candidates whose records and commitments show them to be supporters of a strong health care agenda."

This movement of health care issues from the bleachers to center stage has made physicians vital to those who govern, both as supporters and as information resources. "Ten years ago we had to convince people of the need to talk about medical services for the underserved," says Mitchell Rinek, MD, a Lansing dermatologist and MDPAC chairman. "Now it's an active topic. What civil rights was to the '60s, health care is becoming for the 1990s." MSMS Board Chairman Jack L. Barry, MD, agrees that the need for health care reform has become an unavoidable issue for politicians. "[Legislators] are looking for leadership on health care; they're a lot more aware now. The '37 million uninsured' number has become a buzzword."

Although much maligned, PACs, along with the influence and dollars they represent to candidates, are a needed conduit into the political process. Many groups vie for the attention of political leaders, often with conflicting agendas. The voice of health care, and specifically of Michigan physicians, can be overlooked. Part of the reason for this is the nature and attitudes of physicians themselves. Says Doctor Rinek: "Part of the problems with physicians is, that like farmers, they are individualists, and individual problems take priority over the group. Physicians also have some disdain for the [political] process." Also, physicians tend to be "not very good supporters" of candidates, according to Suzie Pedersen, state chairperson for AMPAC, the national PAC with which MDPAC is affiliated. "Physicians tend to keep a tight grip on their wallets," observes Pedersen. "Also, there isn't unanimity among physicians on issues, and that dilutes their strength."

Candidate interviews key MDPAC strategy

A key part of MDPAC strategy is the series of candidate interviews held with candidates in crucial races. The interviews are largely informal affairs, often taking place at a local restaurant within the congressional district, and involving several community physicians and the candidates. The interviews begin with the primary season, and continue into the autumn.

Physicians bring different questions and agendas to the interviews. "So much of what goes on in the legislature concerns medicine directly," says MSMS Board member Cathy O. Blight, MD, a Flint pathologist. "If people are making decisions on how I work and practice, it's important that I be involved." Doctor Blight consid-

ers it important for physicians to build a long-term relationship with legislators. "They need to see that we care about more than money."

Physicians usually find a broader concern with health issues more important in a candidate than a rote willingness to support narrow physician issues. "Basically I try to discover what their thought process is on health care" says MSMS Board member Krishna K. Sawhney, MD, who is also a member of MDPAC.

And what is the Health Care IQ of those running for office? "In my experience the quality is high," says Pedersen. "But politicians are not free to follow their beliefs. Their first thought is always 'how am I going to get re-elected?'" Doctor Sawhney observes: "A lot of candidates show ignorance, but this ignorance may be in only one field." Says Doctor Rinek: "Some [candidates] are well-versed medically due to their previous experience; but some are less well-informed. We may be educating the candidate for the first time."

This "educability" can be very important. Rochester General Surgeon Peter A. Duhamel, MD, notes that "especially with people running for the first time, they may not know about health care issues, but they should show a willingness to learn. In these cases, we can make a difference, especially in an open seat. If we can educate them, and help them win, they're going to be more friendly."

Candidate interviews are usually well-received by the candidates. "They're generally very receptive," says Bitonti. "Even if they don't accept PAC money, it gives them the opportunity for physicians to know them better. We've never had a problem with them not wanting to meet us."

Long-term dialogue key goal

The end result of these interviews, according to Doctor Duhamel, should be more than a group of physicians giving the candi-

date a clean bill of health and going on their way. The interviews form the basis of a beneficial long-term dialogue between the medical community and the legislator. "As the cost of care goes up, legislators hear back [from constituents] on the issue, and we can then give input," he says. "More doctors involved in politics means more long-term relationships."

Doctor Duhamel sees this communication as more valuable to the candidate than the dollar support. "We're not trying to buy votes...a candidate who's vote you can buy isn't worth the investment. Instead, MDPAC builds a grassroots relationship in each district. The doctors have helped [the candidate], not just with money, but with contacts and introductions. We become the ones he talks to on health care matters." ■

Ralph Ward is a Lansing-based freelance writer.

Physician issues in an election year: Two candidates

By Ralph D. Ward

MDPAC has kept up a busy schedule of candidate interviews for this fall, with strong two-way communication on the issues. What are the candidates saying on health care issues? Two state house candidates endorsed by the MDPAC recently shared their views on the issues, as well as their feelings on legislator/physician relations.

In the 60th district, incumbent Democrat Dianne Byrum faces a tough race against Republican Tom

Truscott, who has been endorsed by MDPAC. Truscott, a first-time electoral candidate, is a teacher and coach at Potterville High School near Lansing, and is father to Governor Engler's Press Secretary John Truscott.

"I've taught history for 31 years," says the candidate, "and I've always taught my students to be involved. With gridlock in the legislature, I thought it was time for new leadership." Truscott's opponent, Dianne Byrum, is new to the Lansing-area district due to a reapportionment move while Truscott points out that he has been a lifelong resident.

Truscott had his first interview with physicians in July. "I felt comfortable with the group" says Truscott. "I felt the questions asked were fair, and I had some thoughts and ideas I wanted to share." Truscott is a supporter of liability caps.

On the issue of scope of practice, the candidate hedged his bets. "I told them that I didn't know the answers, and that I couldn't give an opinion until I had full information. But from my background, it's best if everyone does their job to the best of their ability."

As for overall state health care issues, Truscott tops his shopping list with child health issues. "Immunization should happen whether the child can afford it or not."

Another priority is preventative medicine, prenatal care, and health education on alcohol and tobacco. "We may not be able to meet all the wants, but we should meet all the needs."

The current liability situation appears to Truscott to offer perverse incentives. "Too much is spent on protecting the physician rather than on care." He sees the trial lawyers as being "in after the fact [of malpractice], but my sympathies are with the ones who actually offer the care, the physicians."

The MDPAC endorsement is val-

Continued on following page

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ued by Truscott, especially considering another endorsement he did not receive. After many years as, in his words, a "good soldier" for the Michigan Education Association, the group would not even consider him for support, endorsing his opponent.

Although the race is up for grabs, Truscott already considers himself a winner. I've come out of the process knowing more on health care...I considered this [race] a new challenge. No matter the outcome, this is a no-lose situation."

In the 67th district, Dan Gustafson of Haslett will face Democrat Eric Schertzing in an open race. Gustafson, 33, has served as an Ingham County commissioner for four years, and works for General Motors. He also has strong Michigan political experience at the staff level, working for Senator Matt Dunaskis.

Gustafson met with four MSMS physicians in July, a discussion he found pleasant and familiar. "My wife is a hospital administrator and RN, so I'm used to the environment." The physicians "asked a number of questions on specific issues, questions I felt were designed to seek better health care, not pork barrel concerns." He says he will be "honored" should MDPAC choose to support his campaign, due largely to his shared interest in physician issues.

Among these issues is that of liability, which he sees as part of the overall concern of lowering health care costs. "I'm big on providing health care to everyone at affordable rates." On liability he supports caps on economic damages, pain and suffering. "Liability cannot be unlimited." Scope of practice concerns, however, are ones he "doesn't see as a hot issue."

Gustafson stresses the interconnectedness of health issues, and shuns easy solutions. "The easy answers were used up long ago." ■

Ralph Ward is a Lansing-based freelance writer.

Profile of State House of Representatives General Election Races to Watch!

20th District: Jerry Vorva (R-Plymouth) beat incumbent Representative Georgina Goss (R-Plymouth) in the August 4th primary election. With no Democratic challenger in this 71 percent Republican district, Vorva is sure to win in November.

21st District: Incumbent candidate Jim Kosteva (D-Canton) will be facing a strong Republican challenger, Deborah Whyman (R-Canton) in this 54 percent Republican district. MDPAC plans to do a candidate interview in this race.

26th District: Freshman incumbent candidate Tracy Yokich (D-St. Clair Shores) will be facing a strong Republican challenger, Peter Lund (R-St. Clair Shores) in this 51 percent Republican district. MDPAC plans to do a candidate interview in this race.

29th District: Freshman incumbent candidate Dennis Olshove (D-Warren) will face Republican candidate John Chmurra (R-Canton) in this 51 percent Democratic district. MDPAC plans to do a candidate interview in this race.

34th District: OPEN SEAT Democratic candidate, John Freeman (Madison Heights) will take on Republican candidate Michael McCullough (Royal Oak) in this 56 percent Democratic district. MDPAC plans to do a candidate interview in this race.

42nd District: OPEN SEAT Democratic candidate, Jon Buller (Rochester Hills) will face Republican Greg Kaza (Rochester Hills) in this 69 percent Republican district.

44th District: OPEN SEAT Democratic candidate Bill Glover (Waterford) will take on Republican David Galloway (White Lake) in this 57 percent Republican district.

45th District: OPEN SEAT Democratic candidate Connie Skinner McNealy (Rochester Hills) will take on the MDPAC endorsed candidate, Penny Crissman (Rochester) in this 67 percent Republican district.

51st District: Republican incumbent David Robertson (Swartz Creek) faces a difficult race against Democrat school board member, Candace Curtis (Swartz Creek) in this 54 percent Democratic district.

52nd District: OPEN SEAT Democrat Mary Schroer (Ann Arbor) will take on Republican candidate Mark Ouimet (Ann Arbor) in this 51 percent Republican district. Schroer has

been endorsed by the Michigan Trial Lawyers Association, the Michigan Education Association and the UAW. MDPAC has taken a strong interest in this race as physicians in this district are supporters of Ouimet.

53rd District: OPEN SEAT Democrat Lynn Rivers (Ann Arbor) will take on Republican candidate Terrance Bertram (Ann Arbor) in this 62.5 percent Democratic district. MDPAC plans to do a candidate interview in this race.

55th District: OPEN SEAT Democrat James Douglas (Saline) will take on Republican Beverly Hammerstrom (Temperance) in this 56 percent Republican district. MDPAC plans to do a candidate interview in this race.

60th District: Incumbent Democrat, Representative Mary Brown (Kalamazoo) will face a difficult race against MDPAC endorsed Republican, Jackie Morrison (Kalamazoo) in this 51 percent Democratic district.

67th District: OPEN SEAT Democratic candidate, Eric Schertzing (Williamston) will face Republican candidate Dan Gustafson (Haslett) in this 60 percent Republican district. Both candidates have strong legislative backgrounds, Schertzing having worked for Congressman Bob Carr and Dan Gustafson having worked for State Senator Mat Dunaskis.

68th District: Incumbent Democrat Dianne Byrum (Lansing) will face a difficult race against MDPAC endorsed Republican candidate Tom Truscott (R-Lansing) in this 51 percent Republican district. Tom Truscott is the father of Governor Engler's press secretary, John Truscott.

77th District: OPEN SEAT Democratic candidate, Michael Uskiewicz (Wyoming) will face MDPAC endorsed Republican Harold Voorhees (Grandville) in this 58 percent Republican district.

83rd District: OPEN SEAT Republican candidate Kim Rhead (Sandusky) is unchallenged in the November election in this 60 percent Republican district.

86th District: OPEN SEAT Democratic candidate Dan Sloan (Portland) will face former state lawmaker Republican Alan Cropsey in this 60 percent Republican district.

91st District: Incumbent Democrat Paul Baade (Muskegon) will face MDPAC endorsed Republican candidate Charles Ritchard (Muskegon) in this 55 percent Republican district.

107th District: Incumbent Democrat, House Majority Leader Pat Gagliardi (Drummond Island) will face a tough race against Republican candidate Shannon Brower (Petoskey) in this 54 percent Republican district.



Michigan State Medical Society Annual Scientific Meeting

"Discover the New World of Medicine"

November 17, 18, & 19, 1992

Hyatt Regency Detroit

Chart Your Course

Five hundred years ago, Christopher Columbus embarked on a voyage that led to the beginning of awareness of the New World. Columbus's subsequent discoveries opened up new resources, offered new perspectives, and, ultimately, helped shape the future world.

This year, commemorate the 500th anniversary of Columbus's voyages by embarking on your own journey to "Discover the New World of Medicine." Over 50 half-day courses will be presented at the Michigan State Medical Society's 127th Annual Scientific Meeting, November 17, 18 & 19, 1992. The timely topics, high-quality speakers, and convenient location will open up new resources, offer new perspectives, and, ultimately, help shape the future of medicine in Michigan.

Cast Off Early

This year's "early bird" plenary sessions feature two timely topics: On Wednesday, November 18, Michael Frederick, MD, Director of Hospice of Southern Illinois, will present "Ethical Alternatives to Physician Assisted Suicide." Thursday's plenary session will feature Alexander J. Walt, MB, ChB, Distinguished Professor of Surgery, Wayne State University, presenting "Controversial Issues in the Management of Breast Cancer."



Weigh Anchor for a Once-in-a-Lifetime Opportunity

In a special Tuesday evening dinner event, actress and singer Ann Jillian will speak about the hopeful side of breast cancer in a humorous, entertaining and informative presentation. Plan to join your colleagues, other health care professionals, and their guests at this once-in-a-lifetime opportunity to share in "A Conversation with Ann Jillian."

Additional information about the meeting is included in the following pages. Read on, chart your course, and discover why, if you attend only one professional meeting in 1992, it should be the MSMS Annual Scientific Meeting "Discover the New World of Medicine" — it's a journey you won't want to miss!

Dorothy M. Kahkonen, MD
Chairman, ASM Planning Committee

Set Your Sails for These Special Events

AIDS Provider Education Update

For the first time, the MSMS AIDS Provider Education Project will present its Annual Speakers Bureau update in conjunction with the MSMS Annual Scientific Meeting. Over 100 qualified representatives will be apprised of the most current information regarding HIV, AIDS, and AIDS Education during this special session on Monday, November 16, 1992. For further information regarding this program, contact Tracy Baker, MSMS Coordinator of AIDS Education, (517) 336-5770.

Michigan and Florida CME Credit Available

In addition, the Task Force will sponsor its ever-popular clinical course, "Clinical Issues in AIDS/HIV Management," on Tuesday morning, November 17. Completion of this course will earn 3 hours of Category I CME for Michigan relicensure, and fulfill partial requirements for Florida's requisite AIDS education.

Family Violence Educational Campaign

MSMS President Thomas C. Payne, MD, and the Michigan State Medical Society Auxiliary have set their sights on educating Michigan physicians to lessen the incidence of family violence. Three separate CME approved courses, each focusing on a specific aspect of family violence (child abuse, spouse abuse, and elder abuse), will be presented at the Annual Scientific Meeting by local and national experts.

A special symposium for the public and representatives of various Michigan health, legal and domestic violence agencies also will be held at the Hyatt Regency on Monday, November 16. Physicians at the conference will have the opportunity to join the National Coalition of Physicians Against Family Violence, receiving a mission statement, membership card, and poster expressing the physician's concern and offer of help, for display on office walls. A new MSMS referral guide for Michigan physicians will also be made available at the conference. For further information regarding this campaign against family violence, contact Dawn Reha or Judy Marr at MSMS, (517) 337-1351.

MSMS/AMA Medical Office Staff Series

Invite your medical office staff to attend the MSMS Annual Scientific Meeting! Five separate practice management seminars taught by experts from AMA Financing and Practice Services, Inc., will provide the opportunity for your medical office staff to get years of practical experience. Courses will include Insurance Processing and Coding, The Business Side of Medicine (Personnel, Patient Flow and Financial Management), Advanced CPT-4 and ICD-9-CM Coding, and Medical Collections.

Encourage your staff to attend, and to visit the MSMS Exhibit Hall, regardless of whether they attend the seminars or not! Exhibit hall passes are available to all Michigan physicians and their medical office staff. Order yours on the ASM Registration Form on page 27.

A Conversation with Ann Jillian

We are pleased to welcome a new addition to this year's meeting. Actress and singer Ann Jillian will be with us on Tuesday, November 17 for "A Conversation with Ann Jillian." Ann will share her life experiences with breast cancer in an entertaining and humorous fashion. Ticket prices are \$40 each (includes reception, dinner and program), or \$25 each (for reception and program only.) All physicians, other health care professionals, and guests are invited to share in this presentation about the hopeful side of breast cancer. Reception begins at 5:00 p.m., dinner at 6:00 p.m. and the program at 7:00 p.m. Tickets can be ordered on the ASM Registration Form on page 27.



Even More to Set Your Sights Upon

Adopt a Doctor Discount

The ASM Planning Committee looks forward to continued participation by the hundreds of physicians who attend the MSMS Annual Scientific Meeting each year. Your efforts in promoting the meeting to your colleagues - and the participation by more first-time attendees each year, has resulted in the Adopt-a-Doctor discount program.

If you bring a physician who has never attended (or if *you* have never attended) an MSMS Annual Scientific Meeting, both of you receive one-third off your entire registration for the conference. Simply indicate your name, or that of your "adopted" doctor on the ASM Registration Form on page 27, and subtract the discount from the total amount due.

Continuing Medical Education Credits

"The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for a maximum of 20 credit hours in Category I toward the requirements for Michigan relicensure and of the Physicians Recognition Award of the AMA, provided it is completed as designated." Each half day course earns 3 credit hours, and each plenary session is worth an additional 1 hour of Category I CME.

Traditionally these programs also receive designated credit from the American Academy of Family Physicians. Applications have been forwarded and credit approval will be indicated on the final program. For further information regarding continuing medical education or other credits for attending these courses, contact the MSMS Office of Physician Education, (517) 336-5784.

Over 100 Exhibits to Visit


Now, more than ever, MSMS members will want to visit the 1992 Exhibit Hall at the MSMS Annual Scientific Meeting. There will be exciting new exhibits to visit, updated information on display, and new MSMS endorsed services to investigate. Visit the educational and commercial exhibits, enjoy daily refreshments, participate in door prize drawings, and don't forget to express your appreciation to the many exhibiting firms for their financial support of the meeting.

List of exhibitors on back cover.

Exhibit hall passes are available to all Michigan physicians and their medical office staff. Order yours on the ASM Registration Form on page 27.

Audio Cassettes Available

For your convenience, audio cassettes of each course will be available in the MSMS Exhibit Hall, as well as by mailorder following the meeting. Plan now to purchase tapes of the courses you attend, or of those courses you don't get a chance to attend, to expand your knowledge from the conference.



Schedule of Special Events

Monday, November 16, 1992

Public Symposium on Family Violence

November 16 at 8:30 a.m. to 5:00 p.m.

Seminar

AIDS Provider Education Update

November 16 at 10:00 a.m. to 4:00 p.m.

Speaker Training Update

Exhibitor "Welcome" Luncheon and "The Dynamics of Medical Show Exhibiting"

November 16 at 12:00 noon

Lunch and Program

Tuesday, November 17, 1992

American College of Obstetricians and Gynecologists

November 17 at 5:00 p.m.

Reception

"A Conversation with Ann Jillian"

November 17

Reception at 5:00 p.m.

Dinner at 6:00 p.m.

Program at 7:00 p.m.

Wednesday, November 18, 1992

Michigan Allergy Society

November 18 at 9:00 a.m.

Executive Meeting and Lunch

Michigan Orthopedic Society

November 18 at 3:00 p.m.

Board Meeting

Michigan Society of Colon and Rectal Surgeons

November 18 at 5:30 p.m.

Reception and dinner

Wednesday, November 18, 1992 (continued)

Wayne State University School of Medicine Alumni

November 18 at 6:00 p.m.

Reception

MSMS Committee on Concerns of Women Physicians

November 18 at 12:00 noon

Reception

MSMS Specialty Society Presidents

November 18 at 12:00 noon

Luncheon

Michigan Orthopedic Society

November 18 at 6:00 p.m.

Dinner

Oakwood Hospital - Department of Medical Education

November 18 at 6:00 p.m.

Reception

Thursday, November 19, 1992

Michigan Occupational and

Environmental Medical Association

November 19 at 6:00 p.m.

Reception

Michigan College of Nuclear Medicine

November 19 at 6:00 p.m.

Dinner

Michigan Academy of Plastic Surgeons

November 19 at 6:00 p.m.

Dinner





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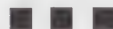
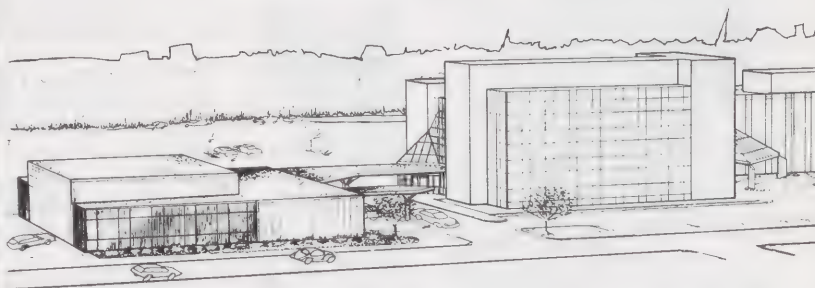
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MEETINGS

MSMS Meetings

September

16, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

15, 16 & 17, MSMS Practice Management Seminar, "Better Collections, Billing and Insurance Methods" and "Reception and Patient Flow Techniques," September 15, Flint Holiday Inn, Flint, MI; September 16, Brookshire Inn, Williamston, MI; September 17, Fetzer Center, Kalamazoo, MI. Contact: Office of Physician Education, (517) 336-5784.

18, 19, & 20, MSMS Practice Management Seminar, "Management & Marketing for the Medical Practice, Grand Hotel, Mackinac Island. Contact: Office of Physician Education, (517) 336-5784.

22, 23 & 24, MSMS Practice Management Seminar, "Coding Institute," by Conomikes Associates, Inc., Bay Valley Resort, Bay City, MI. Contact: Office of Physician Education, (517) 336-5784.

30, MSMS Practice Management Seminar, "Health Law Update," by Kerr, Russell & Weber, Brookshire Inn, Williamston, MI. Contact: Office of Physician Education, (517) 336-5784.

October

5, 8, MSMS/MPMLC Risk Management/Closed Claim Review (pediatrics) Oct. 5, MSMS Headquarters, East Lansing; Oct. 8 Western Michigan University Regional Center, Grand Rapids, MI. Contact: Julie Smith, Chief, Risk Management, (517) 337-1351.

9, 10, Women Physicians Professional Development Conference "Sexual and Gender Harassment in the Medical Workplace." Radisson Hotel, Kalamazoo, MI. Contact: Lori Randall, Chief, Physician Education, (517) 336-5728.

13, 14 & 15, MSMS Practice Management Seminar, "Coding Institute," by Conomikes Associates, Inc., WMU Regional Center, Grand Rapids, MI. Contact: Office of Physician Education, (517) 336-5784.

20, 21 & 22, MSMS Practice Management Seminar, "Coding Institute," by Conomikes Associates, Inc., Hotel Barronette, Novi, MI. Contact: Office of Physician Education, (517) 336-5784.

27, 28, 29, MSMS Practice Management Seminar, "Medicare Update," by Conomikes Associates, Inc., October 27, WMU Regional Center, Grand Rapids, MI; October 28, Brookshire Inn, Williamston, MI; October 29, Hotel Barronette, Novi, MI. Contact: Office of Physician Education, (517) 336-5784.

November

3, 11, MSMS/MPMLC Risk Management "Closed Claim Review (pediatrics)" Nov. 3, Novi Hilton, Novi, MI; Nov. 11, Treasure Island, Saginaw, MI. Contact: Julie Smith, Chief, Risk Management, (517) 337-1351.

4, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI. Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

5, 10, 12, MSMS/MPMLC Risk Management "Practice Parameters." Nov. 5, Novi Hilton, Novi, MI; Nov. 10, Western Michigan University Regional Center, Grand Rapids, MI; Nov. 12, Brookshire Inn, Williamston. Contact: Julie Smith (517) 337-1351.

16, MSMS AIDS Speakers' Bureau Update. Hyatt Regency, Dearborn, MI. Contact: Tracy Baker, Coordinator AIDS Provider Education Project, (517) 336-5770.

16, Statewide Symposium on family Violence, Hyatt Regency Dearborn. Contact: Judy Marr, (517) 337-1351.

17, "A Conversation with Ann Jillian." Hyatt Regency, Dearborn, MI. Contact: Sarah Cressman, Assistant for Physician Education, (517) 336-5727.

17-19, MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 337-1351.

17, 18, 19, 20, MSMS/AMA Medical Office Staff Series, Hyatt Regency, Dearborn, MI. Contact: Office of Physician Education, (517) 336-5784.

NATIONAL SPECIALTY SOCIETY MEETINGS

October

29-31, American Society of Bariatric Physicians, Westin Hotel, Chicago, Ill. Contact: (303) 779-4833.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

September

10-11, Critical Clinical Issues in the Care of the Elderly: Drugs and Their Implications. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan College of Pharmacy and Medical School. **Contact:** Edwina Borde, Registrar, Office of Continuing Medical Education, Towsley Center, P.O. Box 1157, Ann Arbor, MI 48106, (313) 936-9800. **Approved for:** 11 hours Category I Credit.

13, Urban Medicine Symposium III.

Location: Hotel St. Regis Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Family Medicine, Michigan Health Center, and the Detroit Health Department. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 6 hours Category I Credit.

19, Low Back Pain: Diagnosis and Treatment. **Location:** Blue Cross and Blue Shield of Michigan Metro Service Center. **sponsor:** Blue Cross Blue Shield of Michigan. **Contact:** Della SanSouci, (313) 354-8500 Ext. 3827. **Approved for:** 4 hours Category I Credit.

23-24, Office Procedures for Primary Care Physicians. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School and Michigan Academy of Family Physicians. **Contact:** Edwina Borde, Registrar, Office of Continuing

Medical Education, Towsley Center, P.O. Box 1157, University of Michigan Medical School, Ann Arbor, MI 48106, (313) 936-9800. **Approved for:** 16 hours Category I Credit.

15-17, Advances in CT and MRI.

Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Department of Radiology. **Contact:** Edwina Borde, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 764-2651. **Approved for:** 17 hours Category I Credit.

16, Radiologic Technologist Program.

Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Department of Radiology. **Contact:** Edwina Borde, Registrar, Office of Continuing Medical Education, Towsley Center, P.O. Box 1157, University of Michigan

Continued on following page

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CATEGORY I COURSES

Continued from page 71

Medical School, Ann Arbor, MI 48106-1157, (313) 936-9800. **Approved for:** 17 hours Category I Credit.

17-19, 14th Annual Seminar in Diagnostic Ultrasound. Location: Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Department of Radiology. **Contact:** Noceeba Southern, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 764-1422. **Approved for:** 14 hours Category I Credit.

18-19, Urology Update: 1992. Location: Ritz-Carlton, Dearborn, Michigan. **Sponsor:** William Beaumont Hospital, Department of Urology. **Contact:** Jane Moag, Department of Urology Conference, William Beaumont Hospital, 3601 W 13 Mile Road, Royal Oak, MI 48073, (313) 551-0803. **Approved for:** 12 hours Category I Credit.

21-22, Update on Pulmonary and Critical Care Medicine. Location:

Towsley Center, Ann Arbor, Michigan. **Sponsors:** University of Michigan Medical School, Department of Internal Medicine. **Contact:** Edwina Borde, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 936-1678. **Approved for:** 14 hours Category I Credit.

25, HIV & Patients/HIV & Providers: Training Health Care Providers for the Risky World of the 1990's. Location: McGregor Memorial Conference Center, Wayne State University, Detroit, Michigan. **Sponsor:** East Central AIDS Education and Training Center, Michigan Department of Public Health, University of Michigan Medical School. **Contact:** Edwina Borde, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 7 hours Category I Credit.

22, 29, Emotional Expression and Inhibition of the Body. Location: Bar-

Levav Association, Southfield, Michigan. **Sponsors:** Bar-Levav Association. **Contact:** David Fogel, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 4 hours Category I Credit.

October

6, 13, 20, 27, Self Indulgence: A Conscious Resistance or Part of an Illness. Location: Bar-Levav Association, Southfield, Michigan. **Sponsors:** Bar-Levav Association. **Contact:** Joseph Gluski, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 8 hours Category I Credit.

11, Urban Medicine Symposium III. Location: Hotel St. Regis, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Family Medicine, Michigan Health Center, and the Detroit Health Department. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H,

Two Day Workshops On Integrative Child and Play Therapy

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Dates: December 3 & 4, 1992

Dr. Turgay has published over 100 abstracts, papers and chapters on integrative therapies. Selected reprints included in the workshop package. A general review of the field will be covered with emphasis on practical issues through the use of videotaped therapy sessions.

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CATEGORY I COURSES

Detroit, MI 48201, (313) 577-1180. **Approved for:** 6 hours Category I Credit.

12-17, Pediatric Board Review. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Michigan Association of Pediatric Program Directors and Michigan Chapter, American Academy of Pediatrics. **Contact:** Edwina Borde, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 936-9800. **Approved for:** 66 hours Category I Credit.

21-23, A Symposium in Diabetes Care. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Michigan Diabetes Research and Training Center, American Diabetes Association. **Contact:** Robin Rice, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI, 48106, (313) 936-1678. **Approved for:** 20 hours Category I Credit.

22, The Fourth Annual Modern Perinatal Problems. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Robin Rice, Registrar, Office of Continuing Medical Education, Towsley Center, P.O. Box 1157, Ann Arbor, MI 48106, (313) 936-9800. **Approved for:** 15.5 hours Category I Credit.

30, The Future of Mental Health Care - Moving Into the Community. Location: Wayne State University, McGregor Memorial Conference Center, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Psychiatry, Department of Psychology and Alliance for Mental Health Services. **Contact:** Claudia Gold, Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 661-2541. **Approved for:** 6 hours Category I Credit.

31, Brain Mapping/Clinical Neurophysiology of Sleep and Attention Disorders. Location: Northfield Hilton,

Troy, Michigan. **Sponsor:** Beaumont Hospital. **Contact:** Peggy Hanson, RN, Beaumont Hospital Medical Bldg., 44199 Dequindre, Ste. 311, Troy, MI 48098, (313) 879-0707. **Approved for:** 5 hours Category I Credit.

November

1-2, Fiberoptics Workshops for the Difficult Airway. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Anesthesiology. **Contact:** Robin Rice, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI, 48106, (313) 936-1678. **Approved for:** 15 hours Category I Credit.

3, 10, Power in the Doctor-Patient Relationship: Defining its Ethical and Responsible Use. Location: Bar-Levav Association, Southfield, Michigan. **Sponsor:** Bar-Levav Association. **Contact:** Joseph Gluski, MD, 3000

Continued on following page

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CATEGORY I COURSES

Continued from page 73

Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5300. **Approved for:** 4 hours Category I Credit.

4-7, Beyond Character Analysis: Focusing on the Healing Forces in Psychotherapy. **Location:** Bar-Levav Educational Association, Southfield, Michigan. **Sponsor:** Bar-Levav Educational Association. **Contact:** Helene Lockman, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 15.5 hours Category I Credit.

6-7, Endoscopic Sinus Surgery. **Location:** Gordon Scott Hall, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Otolaryngology. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 13 hours Category I Credit.

8, Urban Medicine Symposium III. **Location:** Hotel St. Regis, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Family Medicine, Michigan Health Center, and the Detroit Health Department. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 6 hours Category I Credit.

12-13, Neonatology 1972-1992, Twenty Years of Problems, Progress, and Prospects. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pediatrics. **Contact:** Robin Rice, Registrar, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 936-1678. **Approved for:** 12.5 hours Category I Credit.

December

13, Urban Medicine Symposium III. **Location:** Hotel St. Regis, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Family Medicine, Michigan Health Center, and the Detroit Health Department. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 6 hours Category I Credit.

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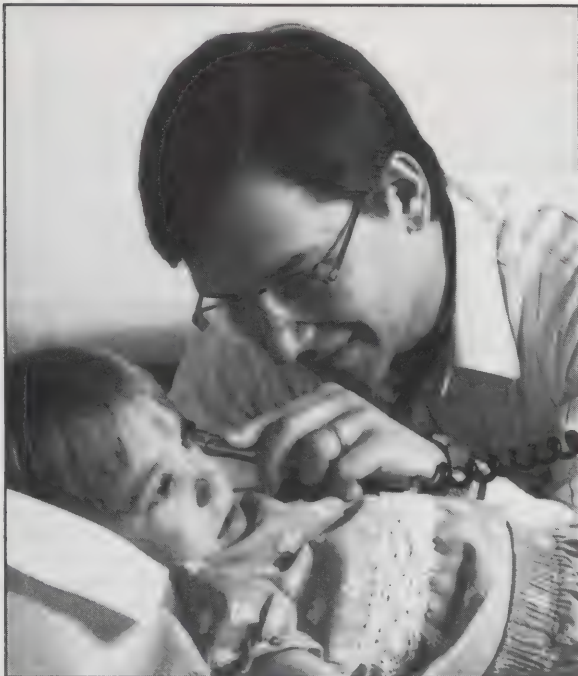
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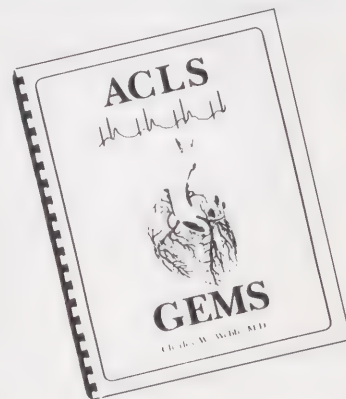
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Continued from page 80

often? Will Michigan become the suicide mecca that the Governor and State Senator Fred Dillingham predict?

"Quick-fix" legislation not the answer

I think even Kevorkian is finally catching on to the fact that each time he assists with a suicide he is pushing the legislature toward a "quick fix" that may do his cause more harm than good. Both Detroit newspapers have editorialized in favor of legislation to make assisted suicide a felony.

Last October in Washington State, a ballot proposal to allow physician-assisted suicide had been leading in the polls, but was narrowly defeated on election day.

Between the polling and the voting, Doctor Kevorkian assisted two women's suicides here in Michigan. Was that a factor in the outcome of the vote? Did his actions produce some fear among Oregonian voters? California now has a similar proposal on its ballot this fall. It will be interesting to see the outcome.

MSMS is taking a lot of heat for our position of wanting further discussions. We continue to maintain that we need more of a societal consensus on the issue and we definitely need more analysis of what exactly constitutes assisted-suicide before we look at any kind of legislation. We continue to work toward those goals and we hope to have some answers in the not too distant future.

Kevorkian to address MSMS Board of Directors

In the meantime, Doctor Kevorkian has written to me to ask for a meeting with the Michigan State Medical Society. In the interest of hearing directly from all involved parties, we have agreed to invite Doctor Kevorkian to address the MSMS Board of Directors at its September 16 meeting. It should be an interesting meeting. Stay tuned. ■

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Physician-assisted suicide

Societal consensus needed
before any legislation can be considered

By Thomas C. Payne, MD

Now what? That's the question we are faced with in the wake of murder charges being dropped against Doctor Jack Kevorkian. An Oakland County Circuit Court judge ruled last month there is no law in Michigan against what he is doing. In his ruling, the judge called on the Michigan State Medical Society and the State Bar of Michigan to work together on what might be appropriate legislation in this area. The judge, and much of the public and even many in the legislature, are not aware that MSMS already is taking the lead on discussions of assisted suicide. We've held six forums in the past eight months, conducted by the chairman of the MSMS Bioethics Committee, Howard Brody, MD.

So far, we have seen some progress from the group that includes representatives from Right to Life of Michigan, the Michigan Hemlock Society, Hospice of Michigan, the Michigan Hospital Association, the State Bar of Michigan, legislators, and many others.

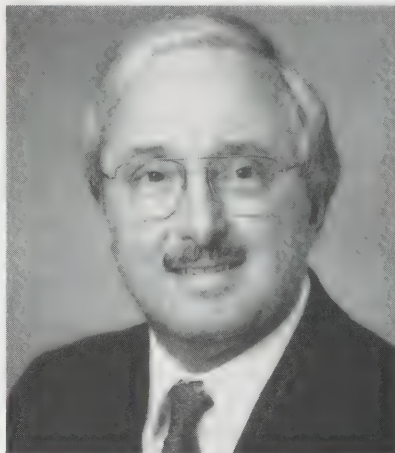
Better pain control a key peripheral issue

Some of the peripheral issues discussed at the forums include pain control, removing life support and advance directives.

In the area of pain control, the groups seems to agree that patients in a great deal of pain should have adequate pain relief. If a physician cannot adequately control a patient's pain, that patient should be referred to a physician who is more experienced in the area. More education should be provided for all physicians in pain management.

Another issue upon which there is some consensus is that a competent patient has the right to remove artificial life support. The case several years ago of David Rivlin is often discussed. He was a young man who became quadriplegic in a surfing accident and was dependent on a ventilator. He wanted to end the life support and the courts upheld his right to do so. When the ventilator was unplugged, he did die.

Finally, the group agrees on the use of an advanced directive in case the patient becomes incapacitated and cannot make his own care and treatment decisions. Michigan's Patient Advocate Act of 1990 allows for a durable power of attorney for health care and clearly spells out the patient's rights and



the patient advocate's responsibilities if called upon to act. MSMS supported this legislation for 16 years and we continue to support living will legislation. Shortly after passage of The Patient Advocate Act, MSMS worked with the State Bar of Michigan, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons to develop a "user friendly" durable power of attorney form. The forms, which do not require an attorney to help complete them, are available for a minimal charge through MSMS. All of the above points should help assure potential "patients" of Doctor Kevorkian that they will not lose control of their own health care and/or suffer miserable and protracted pain.

But what about the law? What about Doctor Kevorkian? Will he assist again soon? And how

Continued on page 79

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Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbo KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbo K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

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MICHIGAN MEDICINE

OCTOBER 1992
VOL. 91, NO. 10

*Award-Winning
Journal of the
Michigan State
Medical Society*



MSMS Annual Scientific Meeting Official Program

**Included are special
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- Continuing Medical Education
- Domestic Violence
- Physician-Assisted Suicide

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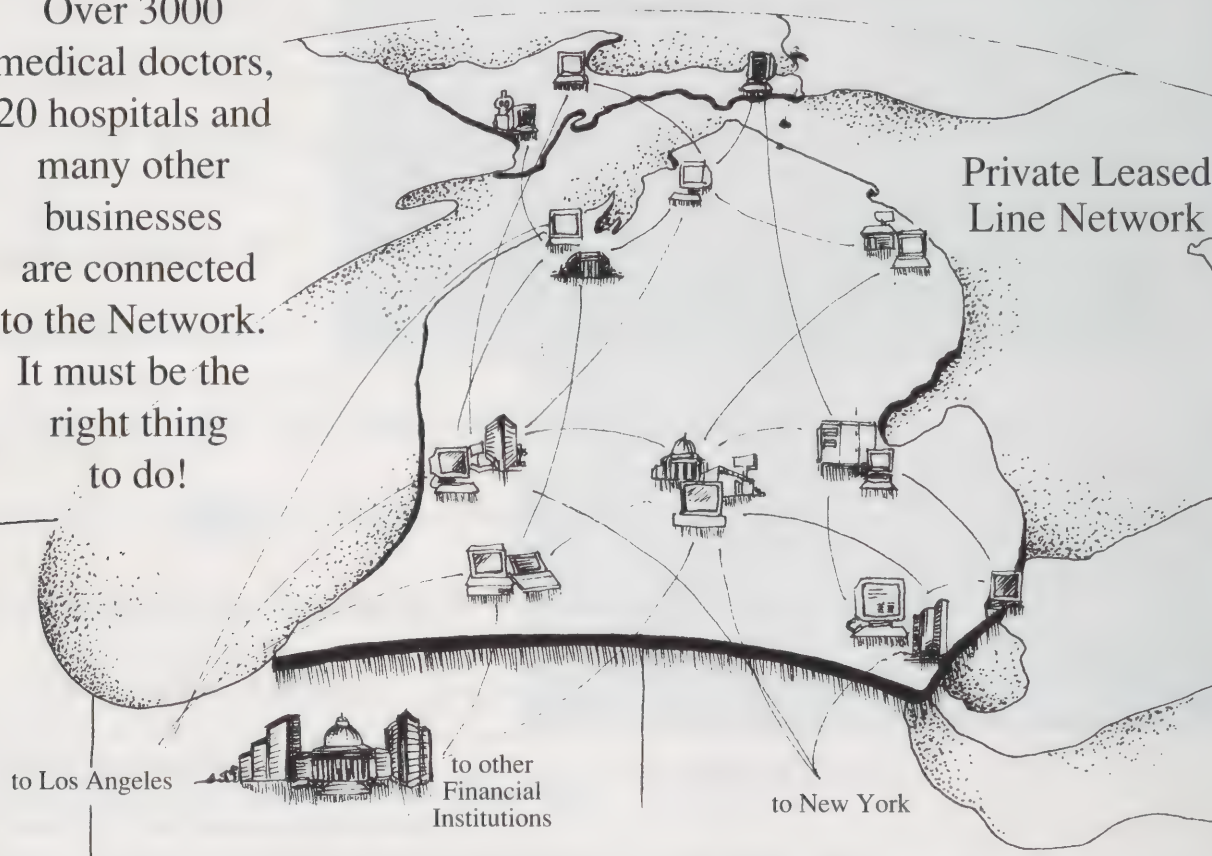
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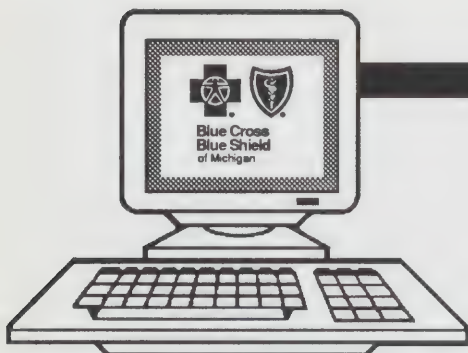


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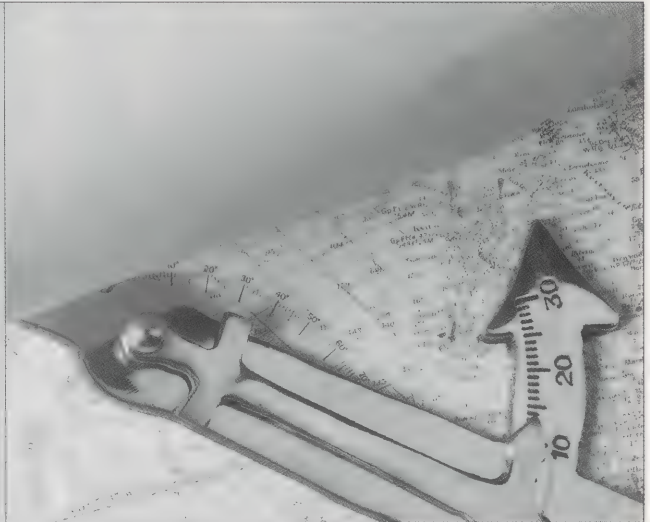
MICHIGAN MEDICINE

OCTOBER 1992 VOLUME 91, NO. 10

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

"Discover the New World of Medicine" is the theme of this year's Annual Scientific Meeting, scheduled for November 17-19 at the Hyatt Regency Dearborn. The meeting will offer more than 50 half-day courses on timely medical issues which cut across all specialties. Continuing its efforts to help make the ASM the best it can be, this month's *Michigan Medicine* serves as the official Annual Scientific Meeting program. The pages which contain course descriptions have been color-coded for easy reference. We hope you find this program informative and simple to use. Program details appear below.



PROGRAM HIGHLIGHTS

"Early Bird" Plenary Sessions

This year's Annual Scientific Meeting will offer two "early bird" plenary sessions on timely topics. The first will feature Michael Frederick, MD, director of Hospice of Southern Illinois, who will discuss "Ethical Alternatives to Physician-Assisted Suicide." The second session will feature Alexander J. Walt, MB, ChB, distinguished professor of surgery, Wayne State University, who will discuss "Controversial Issues in the Management of Breast Cancer."

Family Violence Educational Campaign

Three separate CME-approved courses, each focusing on a specific aspect of family violence (child abuse, spouse abuse, and elder abuse), will be presented by local and national experts. A special symposium for the public and representatives of various Michigan health, legal and domestic violence agencies also will be held at the Hyatt Regency Monday, November 16.

A Conversation with Ann Jillian

Actress/singer Ann Jillian will share her life experiences with breast cancer in an entertaining and humorous presentation Tuesday evening.

Scientific Courses

More than 50 half-day courses offering practical and clinical information will be held during the three-day event.

Exhibits

Approximately 70 exhibitors will be on hand at the Annual Scientific Meeting to meet with attendees.

SPECIAL FEATURE

11

MSMS survey on practice characteristics

DEPARTMENTS

71 MEETINGS

75 CATEGORY I COURSES

80 CLASSIFIEDS

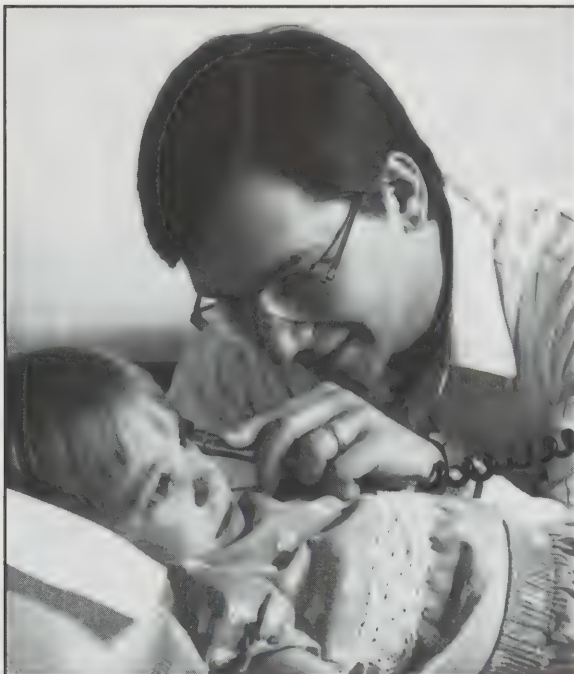
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88 PRESIDENT'S PAGE

In next month's issue:

MSMS Membership

Cover illustration: By Robert L. Brent



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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. **Michigan Medicine** reserves the right to accept or reject advertising copy. Products and services advertised in **Michigan Medicine** are neither endorsed nor warranted by MSMS.

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MSMS SURVEY ON PRACTICE CHARACTERISTICS

MSMS to survey physicians on a variety of topics

By Helen Fordham

Have you ever wondered what the most common health problems are in this state, or what the current health trends are in such areas as AIDS, sexually transmitted diseases, infectious diseases and substance abuse? Have you ever speculated about how liability really affects individual physicians or how many hours physicians work at the office?

If you have, you are not alone. There has been so much interest in collecting data on how Michigan physicians practice medicine that MSMS has organized a survey that will ask questions about a range of topics from practice characteristics to disease trends.

"This is the largest and most comprehensive survey of Michigan physicians that MSMS has ever organized," says MSMS President Thomas C. Payne, MD. "The survey promises to yield very useful information on how physicians practice medicine," he explains. "The results will not only help us measure our own performance but also provide data for public relations and advocacy efforts."

The impetus for the survey is partially the result of a 1992 House of Delegates resolution introduced by Steven Olchowski, MD, which calls for more data on health care delivery and legislative concerns.

"For MSMS leaders to accurately reflect the position of physicians in society, reliable factual data is required," says MSMS Board Member Fred E. Patterson, MD. "Many ad-

versaries of physicians make comments based on information that is not germane to Michigan," he explains. "If we collect reliable, local data we can refute these erroneous claims and advance new causes."

One erroneous claim that has continued to plague Michigan physicians, and may be clarified by the survey, is the trial lawyers' assertion that no health care access prob-

**"This is the largest
and most comprehensive
survey of Michigan
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has ever organized."**

lems are created by liability. MSMS has consistently refuted this, but with data collected about physician's individual experiences MSMS will be in a much stronger position to illustrate the realities of the liability situation in Michigan. Accordingly, the survey will ask questions about how much malpractice coverage physicians have, how much it costs them for coverage, and how often they have been sued.

"This survey provides us with the opportunity to ask and get answers we really need in order to lobby effectively," said Doctor Payne.

Data collected from the survey also will be useful in building a positive public image of physicians. The survey includes questions about how much uncompensated care physicians provide to their patients and how much that care is worth in dollars. Responses to these questions will generate figures that may help balance the negative public image of physicians and allow them to get credit for what they do for their patients, says Julie Lester, chief of Health Care Research for MSMS.

Another program that will benefit from the survey data is the Physician's Well Being Program, according to MSMS Board Member John W. Hall, MD. The program, which is still in the planning stages, will focus on assessing the general well being of physicians. "One of the goals is to help teach physicians to maintain a healthy balance between work and recreation and this is where the survey responses will be useful," says Doctor Hall. The survey will ask questions about how long physicians' work and how many hours they are on call and the responses will give program organizers a sense of physicians' work habits.

The survey also is seeking information on trends in health care, including the sorts of problems physicians see most frequently in their practices. "If we ask questions about infectious diseases or substance abuse or domestic violence

Continued on following page

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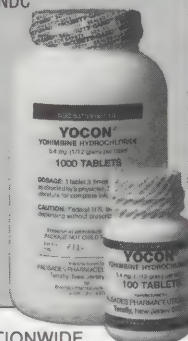
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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Continued from page 11

or environmental health problems this will assist MSMS to highlight areas of public health that need addressing," says Doctor Payne.

Another major aspect of the survey are the questions about office procedure, which will be useful in showing physicians what the average practice is like for a given region or specialty. The survey will include questions about physician incomes, billing procedures and practice management costs. There will be questions about personnel costs and the number of positions for each practice, whether physicians are in group practice or solo, how long they have been in practice and whether the location is rural or urban.

Obtaining specialty, regional data major thrust of survey

Obtaining specialty and regional data of this nature is the major thrust of the survey, says Lester. Currently, information about Michigan physicians is based upon national AMA data, which does not necessarily reflect what goes on at a regional level. According to Lester, the sample for AMA national surveys includes only 175 physicians from Michigan, which may be too small a number to appropriately represent Michigan physicians.

"Our inability to break down national figures can create misleading images at a local level," explains Lester. "If we use a larger sample we will have a much better picture of Michigan demographics."

The survey will be tested in a pilot study with two MSMS committees which will ascertain if all the questions are answerable by physicians and determine how long it will take to fill out the survey. The pilot study also will help to decide if some questions can be answered by office staff. Designers of the survey have attempted to make the survey as clear and concise as possible. Questions will be close-ended and multiple choice, says Lester, which will facilitate simple responses that can be easily quantified for data processing. The survey will only be sent to randomly-selected active physicians.

The survey is strictly confidential, according to Lester, but it will be important to identify where the practice is located in order to provide a regional breakdown.

It is imperative that those who receive the questionnaire answer the questions as completely as possible, stresses Doctor Payne, who encourages all those selected to participate. If the answers are not comprehensive we will have to keep coming back for information, he explains.

The survey will go out the first week in November and the deadline is December 15.

Helen Fordham is chief of community relations for MSMS.

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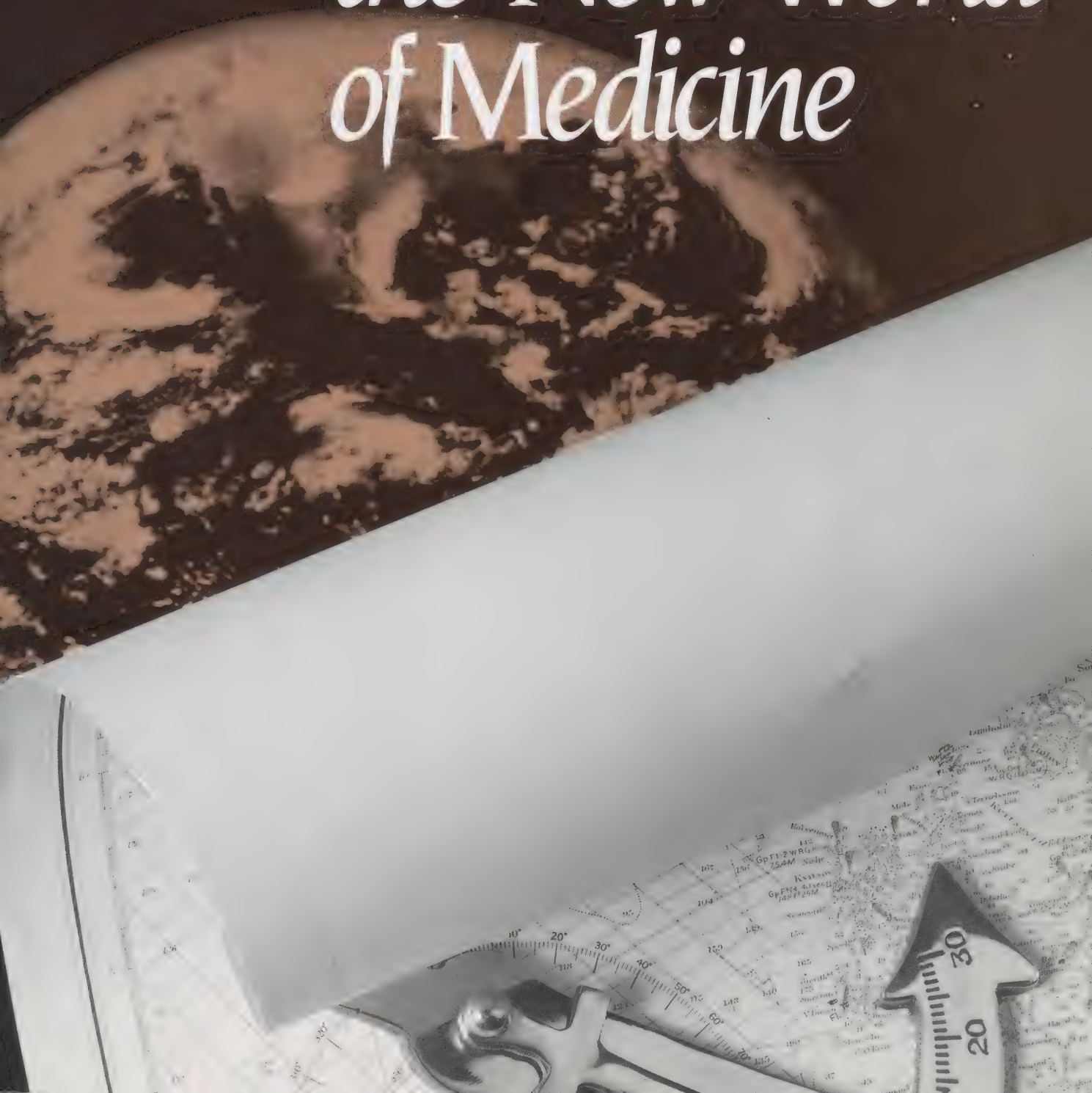
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ASM Planning Committee

Planned by your peers... The Planning Committee for the 1992 MSMS Annual Scientific Meeting is made up of dedicated volunteers from many specialties, practice settings and geographic locations. They have planned the details of this year's meeting with this one purpose in mind: To provide a high standard of educational opportunities, at a reasonable cost, for Michigan physicians. The quality of programming at this year's Scientific Meeting reflects their commitment to that purpose.

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The MSMS Annual Scientific Meeting, in cooperation with the Michigan College of Emergency Physicians, is prepared to handle medical emergencies of all its participants that may occur within the physical confines of the Hyatt Regency Dearborn. A Life Support Station is staffed Tuesday through Thursday during the hours of the meeting by emergency medicine residents from area hospitals and by nurses and/or paramedics from the Lansing area.

IN CASE OF EMERGENCY...In the Hyatt Regency Dearborn, CALL 1280, Tuesday or Wednesday, November 17 & 18, from 8:00 a.m. to 6:00 p.m., and on Thursday, November 19 from 8:00 a.m. to 5:30 p.m. or go to the Life Support Station adjacent to the pool on the first level. **AT ALL OTHER TIMES CALL 2222 AND STATE THE EMERGENCY.** Please read carefully the following:

1. If an emergency (e.g., cardiac arrest) occurs during the hours the Station is open, proceed to the nearest telephone and call 1280. State the floor, area and room the patient is in and the nature of the problem as well as the number of the phone from which you are calling.
2. When the Life Support team arrives, they will assume command of the emergency care. Do not interfere or offer assistance unless asked to do so. Assist with crowd control and open a passageway for evacuation of the patient.
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Welcome

to the 1992 MSMS Annual Scientific Meeting

November 17, 18 & 19

Hyatt Regency Dearborn

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This year, commemorate the 500th anniversary of Columbus's voyages by embarking on your own journey to "Discover the New World of Medicine." Over 50 half-day courses will be presented at the Michigan State Medical Society's 127th Annual Scientific Meeting, November 17, 18 & 19, 1992. The timely topics, high-quality speakers, and convenient location will open up new resources, offer new perspectives, and, ultimately, help shape the future of medicine in Michigan.

This year's "early bird" plenary sessions feature two timely topics: On Wednesday, November 18, Michael Frederick, MD, Director of Hospice of Southern Illinois, will present "Ethical Alternatives to Physician Assisted Suicide." Thursday's plenary session will feature Alexander J. Walt, MB, ChB, Distinguished Professor of Surgery, Wayne State University, presenting "Controversial Issues in the Management of Breast Cancer."

In a special Tuesday evening dinner event, actress and singer Ann Jillian will speak about the hopeful side of breast cancer in a humorous, entertaining and informative presentation. Plan to join your colleagues, other health care professionals, and their guests at this once-in-a-lifetime opportunity to share in "A Conversation with Ann Jillian."



Alexander J. Walt, MD

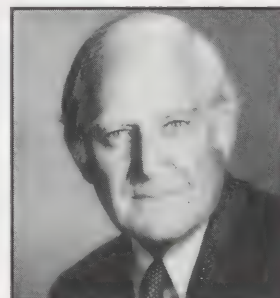
Additional information about the meeting is included in the following pages. Read on, chart your course, and discover why, if you attend only one professional meeting in 1992, it should be the MSMS Annual Scientific Meeting. "Discover the New World of Medicine" — it's a journey you won't want to miss!



Dorothy M. Kahkonen, MD
Chairman,
ASM Planning Committee



Ann Jillian



Michael Frederick, MD

CAPSULE SCHEDULE

OF ANNUAL SCIENTIFIC MEETING

MONDAY, NOVEMBER 16

8:30 a.m. to 5:00 p.m.

Public Symposium on Family Violence

10:00 a.m. to 4:00 p.m.

AIDS Provider Education Update

12:00 noon

Exhibitor "Welcome" Luncheon and "The Dynamics of Medical Show Exhibiting"

TUESDAY, NOVEMBER 17

7:30 a.m.

Registration/Exhibit Hall Open

8:30 a.m.

Concurrent Scientific Courses (until noon)

- Basic Cardiac Life Support
- Clinical Issues in AIDS/HIV Management
- Great Lakes Water Quality: Defining the Human Health Threat
- Identification and Intervention in Family Violence - Focus on Child Abuse
- Multi-Disciplinary Management of the Chronic Pain Patient
- Pulmonary Fibrosis
- Recent Advances in Infertility Therapy
- Emergency Assessment and Management of Acute Cardiac Ischemia
- Wiping out Sinusitis

12:00 Noon

Luncheon For All Registrants

1:30 p.m.

Concurrent Scientific Courses (until 5:00 p.m.)

- Computers in Medicine: From Database to Diagnosis, A Hands-on Workshop
- Current Issues in the Management of the Menopausal Patients

- Current Methods of Treating Breast Cancer
- How to Manage Psychiatric Patients in a World of Shrinking Resources
- Identification and Intervention in Family Violence - Focus on Spouse Abuse
- Immunization Update - Convention & Controversy
- Office Approach to Cardiac Arrhythmias
- Rheumatologic Update 1992
- What's New About Alzheimer's Disease

5:00 p.m.

Reception

American College of Obstetricians and Gynecologists

5:00 p.m.

Reception with Ann Jillian

6:00 p.m.

Dinner with Ann Jillian

7:00 p.m.

Program "A Conversation with Ann Jillian"

WEDNESDAY, NOVEMBER 18

7:00 a.m.

Free "Early Bird" Plenary Session

"Ethical Alternatives to Physician-assisted Suicide"

(Continental breakfast included)

7:30 a.m.

Registration/Exhibit Hall Open

8:30 a.m.

Concurrent Scientific Courses (until noon)

- Basic Cardiac Life Support
- Cardiovascular Risk Factor in the Diabetic Patient
- Computers in Medicine: From Database to Diagnosis, A Hands-on Workshop

- Current Indications and Results of Total Hip and Total Knee Arthroplasty
- Clinical Dermatology
- Flexible Sigmoidoscopy: Indications and Technique
- Identification and Intervention in Family Violence - Focus on Elder Abuse
- Physician-assisted Suicide: Patient and Physician Perspectives
- State of the Art and Future Approaches to Brain Tumors

12:00 Noon

Luncheon For All Registrants

Luncheon

MSMS Committee on Concerns of Women Physicians

Luncheon

MSMS Specialty Society Presidents

1:30 p.m.

Concurrent Scientific Courses (until 5:00 p.m.)

- Allergy/Asthma/Immunology Update - 1992
- Benign Vascular Birthmarks, Psoriasis and Iohthysis
- Colorectal Potpourri
- Common Ophthalmic Problems Faced by the Practicing Physician
- Current Issues Relative to Contraception
- Hypercoagulability and Hemorrhage: Cost Effective Laboratory Diagnosis and Management
- Life and Death Issues of The Sandwich Generation
- Pediatric and Adolescent Athletic Injuries
- Radiology for Clinicians

3:00 p.m.

Meeting and Dinner

Michigan Orthopedic Society

5:30 p.m.

Reception and Dinner

Michigan Society of Colon and Rectal Surgeons

6:00 p.m.*Reception*

Wayne State University School of
Medicine Alumni

Reception

Oakwood Hospital Department of
Medical Education

THURSDAY, NOVEMBER 19**7:00 a.m.**

Free "Early Bird" Plenary Session:

"Controversial Issues in the Manage-
ment of Breast Cancer"

(Continental breakfast included)

7:30 a.m.

Registration

8:30 a.m.

Concurrent Scientific Courses (until
noon)

- A Day in the Office with Your Car-
diac Patients

- Alternatives for Breast Recon-
struction
- Basic Cardiac Life Support
- Current Approaches to the Man-
agement of the Obese Patient
- Laparoscopic Surgery: Pros and
Cons
- Learning Disabilities in Children
- Occupational Skin Disease
- Sports Medicine: Primary Care Is-
sues
- The Clinical Approach to Dis-
eases of the Esophagus

12:00 Noon

Luncheon For All Registrants

1:30 p.m.

Concurrent Scientific Courses (until
5:00 p.m.)

- Clinical applications of Positron
Emission Tomography
- Complications and Side Effects of
Commonly Used Cardiovascular
Drugs

- Physical Activity and the Elderly
- Prevention of Adult Diseases
- Psychiatric Concepts: An Update
- Selected Topics in Plastic Surgery
- Treatment of the Injured Worker
- Classic But Unusual Endocrine
Diseases

6:00 p.m.*Reception*

Michigan Occupational Environmen-
tal Medical Association

Dinner

Michigan College of Nuclear Medi-
cine

Dinner

Michigan Academy of Plastic Sur-
geons

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SPECIAL EVENTS

Capsule Schedule

Monday, November 16, 1992

Public Symposium on Family Violence

8:30 a.m. to 5:00 p.m.

Seminar - New York/Washington (Regency Ballroom)

Lunch - Houston/San Francisco (Regency Ballroom)

Contact: Ms. Judy Marr, MSMS

AIDS Provider Education Update

10:00 a.m. to 4:00 p.m.

Speaker Training Update

Program - Stanley/Steamer (2nd Floor)

Lunch - Bugatti/Royale (2nd Floor)

Contact: Ms. Tracy Baker, MSMS

Exhibitor "Welcome" Luncheon and "The Dynamics of Medical Show Exhibiting"

12:00 noon

Lunch and Program

Atlanta/Chicago (Regency Ballroom)

Contact: Ms. Sarah Cressman, MSMS

Tuesday, November 17, 1992

American College of Obstetricians and Gynecologists

5:00 p.m.

Reception - Cord (2nd Floor)

Contact: Federico Mariona, MD, (313) 593-7818

"A Conversation with Ann Jillian"

Reception at 5:00 p.m. - Hubbard Foyer

Dinner at 6:00 p.m. - Hubbard Ballroom

Program at 7:00 p.m. - Hubbard Ballroom

Contact: Ms. Sarah Cressman, MSMS

Wednesday, November 18, 1992

FREE "Early Bird" Plenary Session

"Ethical Alternatives to Physician Assisted Suicide"

Michael Frederick, MD, Belleville, Illinois

7:00 a.m. - Hubbard Ballroom

Coffee and Rolls included.

Michigan Orthopedic Society

3:00 p.m.

Meeting - Franklin (2nd Floor)

Dinner - Atlanta/Chicago (Regency Ballroom)

Contact: Ms. Joanne Sackett, (616) 242-0355

Michigan Society of Colon and Rectal Surgeons

5:30 p.m.

Reception and Dinner - Stutz/Bearcat

Contact: Ms. Irene Babcock, (313) 282-9400

Wayne State University School of Medicine Alumni

6:00 p.m.

Reception - Rolls/Royce (2nd Floor)

Contact: Ms. Bunny Leach, (313) 577-1495

MSMS Committee on Concerns of Women Physicians

12:00 noon

Luncheon - Stutz/Bearcat

Open to all Women Physicians.

\$12 Lunch Ticket required.

Contact: Ms. Lori Randall, MSMS

MSMS Specialty Society Presidents

12:00 noon

Luncheon - Cord (2nd Floor)

Contact: Ms. Lisa Gorman, (313) 593-5986

Thursday, November 19, 1992

FREE "Early Bird" Plenary Session

"Controversial Issues in the Management of Breast Cancer"

Alexander J. Walt, MS, ChB, Detroit

7:00 a.m. - Hubbard Ballroom

Coffee and Rolls included.

Michigan Occupational and Environmental Medical Association

6:00 p.m.

Reception - Marquis Ballroom (2nd Floor)

Contact: Thomas Hal Morley, MD, (313) 592-5216

Michigan College of Nuclear Medicine

6:00 p.m.

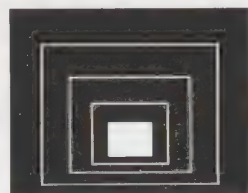
Dinner - New York/Washington (Regency Ballroom)

Michigan Academy of Plastic Surgeons

6:00 p.m.

Dinner - Rolls/Royce (2nd Floor)

Contact: Donald M. Ditmars, (313) 876-2683



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AIDS Provider Education Update

For the first time, the MSMS AIDS Provider Education Project will present its Annual Speakers Bureau update in conjunction with the MSMS Annual Scientific Meeting. Over 100 qualified representatives will be apprised of the most current information regarding HIV, AIDS, and AIDS education during this special session Monday, November 16. For details, contact Tracy Baker at MSMS.

In addition, the Task Force will sponsor its ever-popular clinical course, "Clinical Issues in AIDS/HIV Management," on Tuesday, November 17. Completion of this course will earn 3 hours of Category I CME for Michigan relicensure, and fulfill requirements for Florida's requisite AIDS education.

Family Violence Educational Campaign

Three separate CME-approved courses, each focusing on a specific aspect of family violence (child abuse, spouse abuse, and elder abuse), will be presented by local and national experts. A special symposium for the public and representatives of various Michigan health, legal and domestic violence agencies also will be held at the Hyatt Regency Monday, November 16.

MSMS/AMA Medical Office Staff Series

Five separate practice management seminars taught by experts from AMA Financing and Practice Services, Inc., will provide the opportunity for medical office staff to get years of practical experience. Courses will include insurance processing and coding; the business side of

medicine (personnel, patient flow and financial management), advanced CPT-4 and ICD-9-CM coding, and medical collections.

"Early Bird" Plenary Sessions

This year's Annual Scientific Meeting will offer two "early bird" plenary sessions on timely topics. The first will feature Michael Frederick, MD, director of Hospice of Southern Illinois, who will discuss "Ethical Alternatives to Physician-Assisted Suicide." The second session will feature Alexander J. Walt, MB, ChB, distinguished professor of surgery, Wayne State University, who will discuss "Controversial Issues in the Management of Breast Cancer."

A Conversation with Ann Jillian

Actress/singer Ann Jillian will share her life experiences with breast cancer in an entertaining and humorous presentation Tuesday evening.

Annual Sports Medicine Conference

MSMS, in cooperation with the Michigan Orthopaedic Society, Michigan Athletic Trainers Society, and the Michigan High School Athletic Association, is offering three half-day sessions on Sports Medicine during the Annual Scientific Meeting. CME-approved courses on "Pediatric and Adolescent Athletic Injuries," "Sports Medicine: Primary Care Issues;" and "Physical Activity and the Elderly" will be held on Wednesday and Thursday. ■

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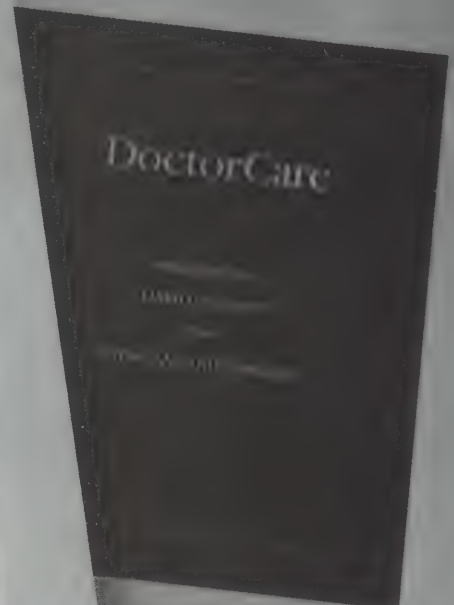
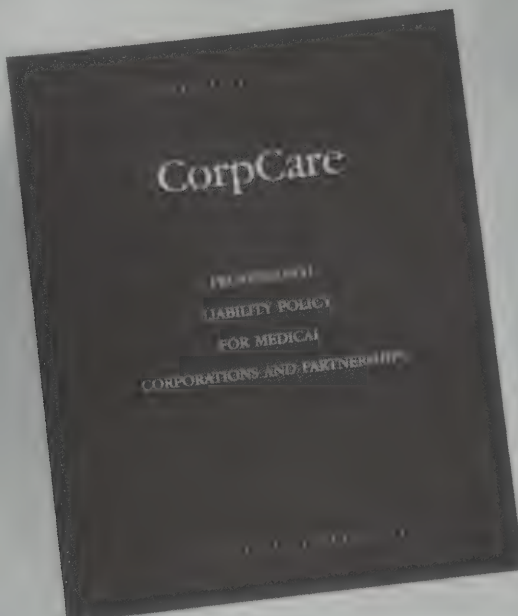
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GENERAL INFORMATION

REGISTRATION: The registration desks will be located in the Great Lakes Exhibit Center, First Floor, Hyatt Regency on Tuesday and Wednesday. On Thursday registration will be located on the first floor behind the elevators in the main lobby of the Hyatt Regency.

MSMS MESSAGE CENTER: Special telephone lines will be installed for incoming, local and long distance calls. Just call the Hyatt Regency, 313/593-1234 and ask for the MSMS Message Center. Be sure you check the Message Center Board in the Exhibit Hall regularly for posted messages.

COAT CHECK: Complimentary coat check will be available adjacent to the MSMS Registration Desk and will operate at the same times. Please remember to pick up your coat before going to any evening functions. Items left at the coat check will be locked away until the following morning.

ADMISSION TO COURSES: Admission will be by Course Admission Tickets which will be given to physicians when they register. No one will be admitted to courses without tickets and/or badges. All courses begin promptly at 8:30 a.m. or 1:30 p.m.

FACULTY HEADQUARTERS: Course directors and instructors can use the Indianapolis Suite on the First Floor (near the pool) as a place to meet, review slides or course material, etc.

NO SMOKING PLEASE: All participants are asked to refrain from smoking while courses are in session. There will be a half-hour break in all courses. The no-smoking policy has been in effect since 1977.

FRESH COFFEE: Coffee will be available on Tuesday and Wednesday in the Exhibit Center, and at separate stations near the first and second floor course rooms on Thursday. Coffee service is provided compliments of the exhibitors and the Michigan Society of Medical Assistants.

LUNCHEON TICKETS: Complimentary tickets for Tuesday's and Wednesday's Deli lunch and for Thursday's served luncheon are available for paid registrations received in advance of the meeting. A limited number of tickets may still be available for purchase at the Registration Desk.

EXHIBIT CENTER: Participants are urged to visit the outstanding displays featured in the Great Lakes Exhibit Center and to express their support for the exhibitors' financial contribution to the meeting. Exhibits are open Tuesday and Wednesday from 7:30 a.m. to 3:30 p.m. and again from 5:00 p.m. to 6:00 p.m. for an early evening reception sponsored by the exhibitors.

NEW THIS YEAR...Free passes are available for registered participants to invite their colleagues and/or staff to visit the exhibit hall on Tuesday. On Thursday, we will feature

a new exhibitors networking luncheon. The Exhibit Center will not be open on Thursday.

Daily doorprize drawings will be held, with incentives for visiting the participating booths. A variety of prizes for physicians' personal and professional use have been donated by the exhibitors. Winners will be selected during the afternoon and will be posted during the evening receptions.

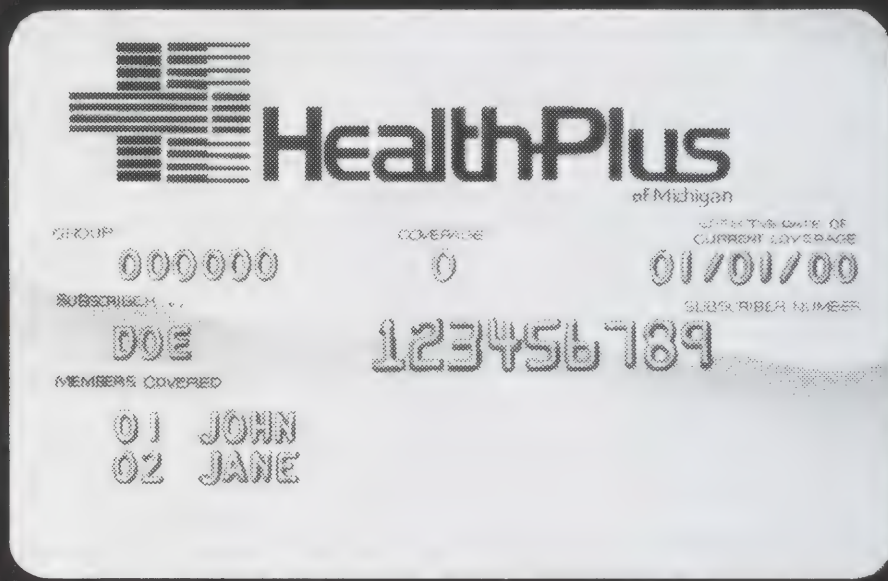
CATEGORY I CREDITS: The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 20 credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed. This program has been reviewed and is acceptable for 20 Prescribed hours by the American Academy of Family Physicians.

CERTIFICATES OF PARTICIPATION in Category I courses will be provided to physicians at the end of each course. Physicians should keep these certificates on file as proof of their attendance.

MEDIA: Medical writers and representatives of television and radio have been invited to cover the annual Scientific Meeting. MSMS staff will be available all three days in the Indianapolis Suite to provide assistance.



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OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

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Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS: Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. **Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. **Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Use in Pregnancy: Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. **Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. **OVERDOSAGE: Acetaminophen Signs and Symptoms:** In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised March 1992

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Attend the ASM and earn up to 20 hours of Category I credit

Now in its 127th year, this year's MSMS Annual Scientific Meeting will offer more programs than ever before

By Helen Fordham



For physicians, keeping up with advances in one's specialty can be difficult. There is so much new medical information that staying on the cutting edge is a true challenge, indeed.

To help physicians stay current and comply with the Michigan Board of Medicine's requirement that they complete 150 hours of continuing medical education every three years, the Michigan State Medical Society offers its much-heralded Annual Scientific Meeting (ASM).

The ASM, which is in its 127th year, is the largest medical conference in the state. Last year, the meeting attracted 900 physicians, but this year's program promises to be the largest ever held. Fifty-three courses, approved for Category I CME credit, have been scheduled over the three-day conference. In addition, all courses are approved for family physicians prescribed credits.

"Michigan has two categories of medical education," explains David Rovner, MD, chairman of the MSMS Committee on CME Programming. "Category I focuses on improving patient care by teaching clinical skills," he says. "In Michigan, physicians must have at least half of their 150 hours as Category I, and many of those hours can be obtained at the Scientific Meeting."

Physicians presenting courses can also receive CME credit, as can those who listen to the audio tapes of the sessions.

Michigan has one of the strictest CME requirements in the nation, according to American Medical Association data. It is the only state that requires 75 Category I credit hours. Of all 50 states, only 27 have CME requirements. In Michigan, physicians can be randomly

audited to ensure they are keeping up with their credits, says Doctor Rovner, and their license can be revoked if they have not. "With these tough requirements, the ASM provides physicians the opportunity to attend courses in their specialty areas and in a variety of other specialties so they can get their much needed credits," he explains.

Many topics to be addressed

This year's meeting has a variety of programs which range from the latest developments in Alzheimer's disease to clinical issues in AIDs and HIV management to the health threat posed by the Great Lakes water. There will also be sessions on current treatment of breast and prostate cancer, management of chronic pain, computers in medicine and state of the art approaches to brain tumors.

"We have tried to put together a program that is of interest to the physicians and useful in expanding their skills," says Dorothy

Kahkonen, MD, chairman of the MSMS Annual Scientific Meeting Planning Committee.

Domestic violence

The organizers of the program have also striven to provide courses that promote existing AMA and MSMS programs. This includes domestic violence, which both MSMS and the AMA have made a major theme for 1992. "We have three programs on domestic violence and each will focus respectively on child, adult and elder abuse," Doctor Kahkonen explains.

"...the ASM provides physicians the opportunity to attend courses in their specialty areas and in a variety of other specialties so they can get their much needed credits."

Continued on following page

Continued from page 25

A public symposium on domestic violence also will be held November 16. Representatives from public health, department of social services, shelters, and citizens for better care are among those who will be invited to attend. Courtney Esposito, from New Jersey, will make a presentation on breaking the cycle of violence and share her experiences as an abused wife. The afternoon session will be devoted to a panel discussion of the many aspects of domestic violence. The panel will include abuse experts, law enforcement and legislative specialists, and those who work with the abused and abusers.

"This symposium provides a unique opportunity for physicians and other specialists to work together with the community to share information about domestic violence and find ways we can work to improve the situation," says MSMS President Thomas C. Payne, MD, who serves as coordinator of the symposium.

Physician-assisted suicide

Domestic violence is not the only topical issue that will be covered at the ASM. Physician-assisted suicide is the focus of a program devoted to profiling those patients likely to ask for assistance and those physicians likely to provide it. There also will be a plenary

session on pain management as an alternative to assisted suicide.

Breast cancer

A new addition to this year's program is a segment entitled, "A Conversation with Ann Jillian," who will share her experiences with breast cancer. To complement this presentation Alexander J. Walt, MD, professor of surgery at Wayne State University, will present a session on "Controversial Issues in the Management of Breast Cancer."

Although physician education is the focus of the ASM, organizers would like the conference to be a learning experience for medical office staff as well. Practice management courses will include insurance processing and coding, the business side of medicine, advanced CPT-4 and ICD -9-CM coding and medical collections.

Pulling the ASM together requires year-round planning. "Courses are solicited for the next ASM immediately after the previous ASM has concluded," says Doctor Kahkonen. "Input is solicited from hospitals, universities and specialty societies," she adds. "But any practicing physician is encouraged to develop a course proposal." ■

Helen Fordham is chief of community relations for MSMS.

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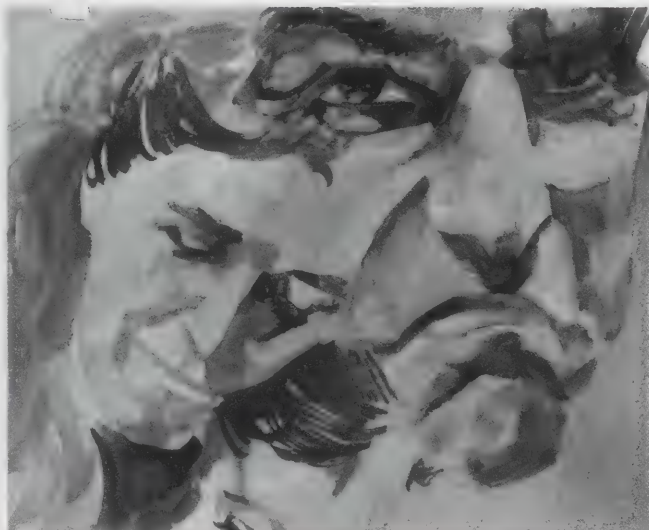
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DOMESTIC VIOLENCE

MSMS Annual Scientific Meeting to promote importance of recognizing, treating domestic violence



By Helen Fordham

Family violence and its impact on the health of the community is a major theme of the AMA and MSMS for 1992. It is also an important theme of this year's MSMS Annual Scientific Meeting.

"The ASM is a great opportunity to let physicians know domestic violence is a pervasive societal problem that effects the health of the community," says MSMS President Thomas C. Payne, MD, who is committed to raising public and physician awareness of the damage wrought by family abuse.

"We pay an awful price for the ravages of domestic violence, whether it's child abuse, child sexual abuse, spouse abuse or elder abuse. The cycle of domestic violence continues to afflict generation after generation, and it costs society billions of dollars every year to deal with the effects of this societal cancer."

One of Doctor Payne's goals is to help Michigan physicians recognize and treat patients who may have experienced, or are experiencing, one of the many forms of domestic violence.

To help him in this goal, organizers of the MSMS Annual Scientific Meeting have developed three half-day programs that will focus on child, adult and elder abuse and ways physicians can identify and intervene in incidences of suspected abuse.

The programs will promote the new AMA treatment guidelines for child sexual abuse, physical abuse and neglect and domestic violence. "These guidelines will help physicians and other health care professionals to identify and treat cases of abuse," says Doctor Payne.

An exciting range of state and national speakers has been invited to participate in the domestic violence programs. Among them is David Chadwick, MD, director of the Center for Child Protection, San Diego, Cali-

Continued on following page

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fornia. He is co-author of the book, "The Atlas of Physical Findings of Child Abuse," and has contributed to the development of the AMA guidelines on child abuse. Joining him on the child abuse program are two nationally-recognized experts: Katherine Coulborn Faller, PhD, professor of social work at the University of Michigan and director of the Family Assessment Clinic; and David K. Hickok, MD, a Kalamazoo pediatrician.

The program on elder abuse will be presided over by James G. O'Brien, MD, who is chairman of the MSMS Task Force on Aging and the AMA Elder Abuse Working Group. The program on spouse abuse will be led by Rhoda M. Powsner, MD, Washtenaw County Medical Society president and member of the AMA Advisory Committee on Family Violence.

To launch MSMS's domestic violence campaign MSMS held a public forum on August 19 which included representatives from these organizations: the Michigan Department of Public Health, the Michigan Hospital Association, the State Bar of Michigan, Citizens for Better Care and the Department of Social Services Violence Prevention Board. The forum also included physicians, county medical society executives and heads of emergency shelters. These individuals met to

discuss ways to promote awareness of domestic violence in the community and among physicians.

Representatives from these same groups have been invited to attend a public symposium, which will be held November 16, one day prior to the official opening of the ASM. Courtney Esposito, from New Jersey, will give a presentation on breaking the cycle of violence and share her experience as an abused wife.

The afternoon session will be a panel discussion and representatives from various Michigan health, legal and domestic violence agencies will participate in a discussion to highlight the problems they face in dealing with this issue.

Physicians at the symposium and the individual programs will also have the opportunity to join the National Coalition of Physicians Against Family Violence, receiving a mission statement, membership card and poster expressing the physicians concern for victims of abuse.

"The ASM will go a long way in promoting the importance of recognizing and treating domestic violence," says Doctor Payne, who stresses that informed physicians can help break the cycle of domestic violence. ■

Helen Fordham is chief of community relations for MSMS.

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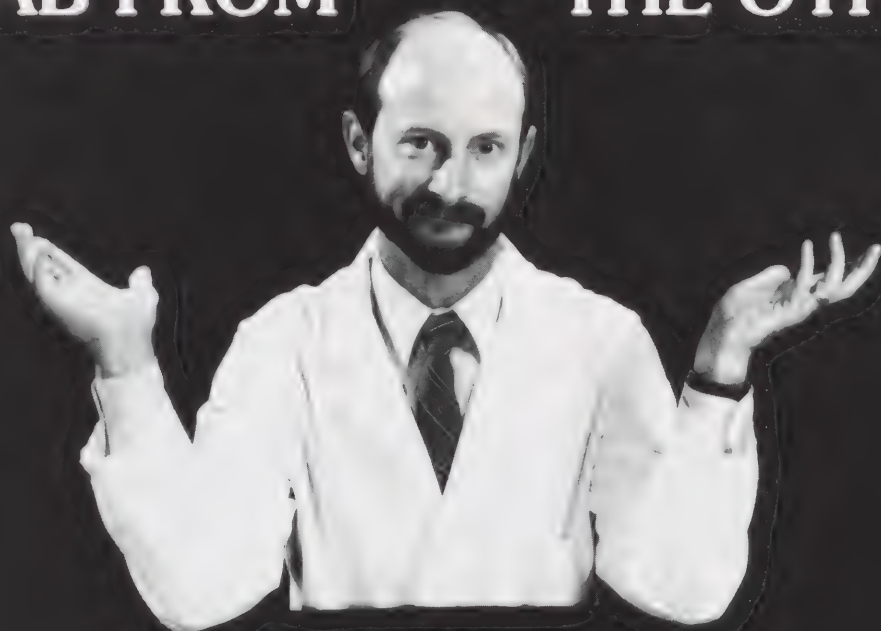
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ASSISTED SUICIDE

Pain management to be the focus
of session on physician-assisted suicide



Jack Kevorkian, MD, recently addressed the MSMS Board of Directors on the ways he would implement assisted suicide. His presentation was "merely part of MSMS' on-going efforts to listen to as many people as possible who are concerned with this issue," said MSMS Board Chairman Jack L. Barry, MD.

By Helen Fordham

With all the discussion about physician-assisted suicide have you ever wondered about the type of patient that would ask for assistance in dying? Or have you ever thought about what type of physician would provide that assistance (aside from Doctor Kevorkian)? Have you ever speculated about what alternatives exist to assisted suicide or how non-physician concerns are influencing the debate?

Some answers to these questions will be provided at this year's MSMS Annual Scientific Meeting.

Physician-assisted suicide has had a long and tumultuous history as MSMS has wrestled with the issue for the last two years.

The most recent development in the ongoing saga was the September 16 presentation by Jack Kevorkian, MD, to the MSMS Board of Directors on the ways he would implement assisted suicide. His presentation was part of a public information gathering session, says MSMS Chairman of the Board, Jack L. Barry, MD, who stresses that the address did not mean that MSMS was working with Kevorkian or that MSMS has taken a position on assisted suicide. "Doctor Kevorkian's presentation is merely a part of MSMS's ongoing efforts to listen to as many people as possible who are concerned with this issue," explains Doctor Barry.

“We realize that physician-assisted suicide is a societal issue and one that cannot be resolved by physicians in isolation. The issue has ethical, moral and legal ramifications, so it is important to listen to what others in the community have to say about this issue.”

Public forums crucial

MSMS has been listening to those concerned about physician assisted suicide for almost a year in a series of public forums. "We realize that physician-assisted suicide is a societal issue and one that cannot be resolved by physicians in isolation," says Howard A. Brody, MD, PhD, chairman of the MSMS Committee on Bioethics. "The issue has ethical, moral and legal ramifications, so it is important to listen to what others in the community have to say about this issue," he says.

There have been seven forums over the last 10 months. These forums have been information-sharing sessions and input has been solicited from a range of concerned groups including Right to Life of Michigan, Hospice, Hemlock Society, American Civil Liberties

Union, Michigan Bar Association and the Michigan Nurses Association. "By listening to the public we can find out what patients expect of us and what leads them to trust or not trust us," says Doctor Brody.

The public forums have been helpful in providing the Committee with some insights into not only how non-physicians perceive this issue but also what may be motivating the public's demand for assisted suicide.

These insights have been useful in helping to shape the courses on physician-assisted suicide offered at the ASM.

Perhaps one of the most important discoveries from the public sessions is that fear of inadequate pain and symptom management may be driving the public's demand for assisted suicide. Patients also fear they will be excluded from the decision-making process and that they will not have access to advance directives.

"During the public forums testimony has been heard which indicates compliance with these measures is quite uneven among Michigan physicians and hospitals," says Doctor Brody. "In addition, the public appears not to have the necessary confidence that their rights and needs will be respected by the average Michigan physicians should they face terminal or chronic illness. Participants in the forum, although deeply divided over the ethical and moral implications of assisted suicide, have agreed that regardless of physician-assisted suicide, something needs to be done to address these fears, explains Doctor Brody.

The Committee on Bioethics affirmed the importance of pain management within the context of physician-assisted suicide in 1990 when it issued a joint statement with the MSMS Judiciary Commission. The statement listed the following as appropriate responses to the challenges raised by Doctor Kevorkian's suicide machine.

- Physicians should be acquainted with the most up-to-date methods of symptom control in terminal care.
- Physicians should assure patients that their wishes will be considered in all decisions to use or forego medical treatment.
- Physicians should assist in counselling patients on the effective use of advance directives.

"Addressing these issues and alleviating pain may be an important step in dealing with requests for assisted suicide," says Doctor Brody. Accordingly, the Committee on Bioethics is working on developing pain management seminars for both health care professionals and the public for 1993.

"These sessions will focus on pain management and advance directives like Durable Power of Attorney," says James Waun, MD, member of the Bioethics Subcom-

mittee, which is developing guidelines for the development of these seminars. "By educating physicians about better management of pain and suffering and the public about what they have a right to expect from their physicians we may make strides toward reducing the clamor for physician-assisted suicide," he says. The Committee on Bioethics believes uniformly that pain management is a critical aspect of the physician-assisted debate and plans to work with other MSMS committees, like the Committee on Aging, as well as other independent organizations to develop the seminar programs.

Pain management critical

Pain management, therefore, has been recognized as a critical aspect of physician-assisted suicide and will be the focus of the 1992 Annual Scientific Meeting's Wednesday morning plenary session, entitled, "Ethical Alternatives to Physician-Assisted Suicide." The free session, which has CME credit, will be delivered by Michael Frederick, MD, medical director of Hospice of Southern Illinois. His presentation will focus on the importance of adequate pain management and other end of life alternatives.

The public forums also have been useful in highlighting the conflict between physician ethics and public ethics in resolving the physician-assisted suicide issue. The Genesee County Medical Society Bioethics Committee, at the direction of the MSMS Committee on Bioethics, has developed a half-day session on assisted suicide that will examine this conflict.

"We want to compare non-physician ethics and concerns with physician ethics and concerns and demonstrate how they each affect the discussion of physician-assisted suicide," explains John W. Tauscher, MD, chairman of the Genesee County Bioethics Committee. "We are trying to bring the ethical and the human dimensions of this debate together in this session."

The program will also explore physician-assisted suicide from the perspectives of a medical ethicist, Greg Triantosky, PhD, and forensic psychiatrist, Emanuel Tanay, MD. These two speakers will highlight the ethical and moral issues associated with physician-assisted suicide and profile the types of patients that are likely to ask for assistance in dying and the types of physicians likely to aid them.

"The session should be very interesting," says Doctor Tauscher. "It is designed to give an overview of the complexity of the physician-assisted suicide issue." ■

Helen Fordham is chief of community relations for MSMS.

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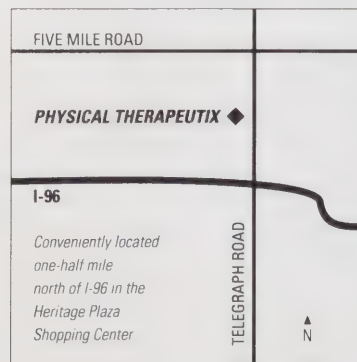
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COURSE SCHEDULE



Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan College of Emergency Physicians

This course will include lectures and practical situations for teaching Basic Cardiac Life Support according to the American Heart Association guidelines. The practical sessions will include hands-on teaching of cardiopulmonary resuscitation, obstructed airways in unconscious and conscious victims, including infants, and CPR. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Vice Chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing

PRESIDING: Doctor Orr

SPEAKERS:

Greg Baker, BCLS Instructor, East Lansing Fire Department

Glena Christiansen, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Debra Deford, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Laura Lane, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Anthony Meholic, BCLS Instructor, St. Lawrence Hospital, Lansing

Doctor Orr

Clinical Issues in AIDS/HIV Management

PRESENTED BY: MSMS AIDS Provider Education Project

This course will provide primary care physicians an understanding of the pathophysiology and natural history of Human Immunodeficiency Virus (HIV) infection. Special areas of focus will include management of the asymptomatic seropositive patient (including new information about *Pneumocystis carinii* prophylaxis), management and natural history of pediatric HIV infection, management of the symptomatic outpatient (including information about DDI and DDC use), and management of inpatients with opportunistic infections.

COURSE DIRECTOR: Daniel Havlichek, MD, Associate Professor, Department of Medicine, Michigan State University College of Human Medicine

PRESIDING: Doctor Havlichek

SPEAKERS:

Reynard Bouknight, MD, Associate Professor, Department of Internal Medicine, Michigan State University College of Human Medicine

"Natural History of HIV Infections and Management of the Asymptomatic Seropositive Patient"

Doctor Havlichek

"Management of the Symptomatic HIV (+) Outpatient"

Maria Patterson, MD, PhD, Professor, Division of Pediatrics, Michigan State University College of Human Medicine

"Pediatric HIV Infections"

Eyassu Habte-Gabr, MD, Division of Infectious Disease, Hurley Hospital, Flint

"Diagnosis and Management of Serious Opportunistic Infections in HIV (+) Inpatients"

Great Lakes Water Quality: Defining the Human Health Threat

PRESENTED BY: MSMS Task Force on Environmental Health

Last May the MSMS House of Delegates passed a resolution supporting "Zero Discharge" of PCBs and dioxin in the Great Lakes Basin. This symposium will explore the human health threat of Great Lakes water pollution.

COURSE DIRECTOR: Robert M. Soderstrom, MD, FACP, Dermatologist, Flint; Diplomate, American Board of Internal Medicine and American Board of Dermatology

PRESIDING: Doctor Soderstrom

SPEAKERS:

James Ludwig, PhD, Certified Senior Ecologist, Ecological Society of America

"Wildlife Monitoring Studies, Biological Markers, Contamination Data, and Population Studies Which Serve as Surrogates of Human Health Defects"

Joseph Jacobson, PhD, Professor, Department of Psychology, Wayne State University School of Medicine

"Effects of Prenatal Exposure to PCBs on Fetal Development"

Gordon Durnil, Chairman, United State Commissioners, Internal Joint Commission

"International Joint Commissions Sixth Bienial Report on Great Lakes Water Quality"

Identification and Intervention in Family Violence - Focus on Child Abuse

PRESENTED BY: MSMS Auxiliary

The course objectives are to increase the awareness levels of physicians and others to the issue of child abuse, educate as to guidelines in dealing with child abuse, review the reporting and notification requirements when confronted with child abuse, and discuss utilization of clearinghouses for dissemination of information dealing with this issue.

COURSE DIRECTOR: Thomas C. Payne, MD, MSMS President; Radiologist, Lansing Radiology P.C.

PRESIDING: Doctor Payne

SPEAKERS:

David Chadwick, MD, Director, Center for Child Protection, San Diego, CA

"Physical Abuse"

Kathleen Coulborn Faller, PhD, Social Work and Psychology Director, Family Assessment Clinic, University of Michigan; and Co-Director, Interdisciplinary Project on Child Abuse and Neglect

"Social/Psychological Consequences of Abuse"

David K. Hickok, MD, Kalamazoo Pediatrician, Evaluates Sexually Abused Children; Consultant, Kalamazoo County Multidisciplinary Team on Child Abuse

"Sexual Abuse"

Multi-Disciplinary Management of the Chronic Pain Patient

PRESENTED BY: Department of Neurosurgery, University of Michigan Medical School

This course is designed for practitioners managing patients with chronic pain due to benign or malignant disease. The value of a multi-disciplinary approach to the chronic pain sufferer will be demonstrated by utilizing several case presentations. Together the presenters will address the following areas: Range of problems encountered; Evaluation process and development of a treatment plan; Therapeutic outcomes with state-of-the-art pharmacologic, neuro-augmentative, and psychologic methods; Establishing continuity of care of ongoing problems through interface with the larger health-care community. A closing panel discussion will focus on cases submitted by the audience.

COURSE DIRECTOR: James A. Taren, MD, Professor, Department of Neurosurgery, University of Michigan Hospitals

PRESIDING: Doctor Taren

SPEAKERS:

Doctor Taren

Alexis M. DeRosayro, MD, Clinical Associate Professor II, Department of Anesthesiology, University of Michigan Medical Center

Vildan Mullin, MD, Clinical Assistant Professor II, Department of Anesthesiology, University of Michigan Medical Center

Randy S. Roth, PhD, Associate Director, Department of Clinical Psychology, University of Michigan Medical Center

Margie VanMeter, RN, MS, Clinical Nurse Specialist, Coordinator, Chronic Pain Clinic, University of Michigan Medical Center

Susan V. Grube, RN, BSN, Clinical Research Associate, Section of Neurosurgery, University of Michigan Medical Center

Pulmonary Fibrosis

PRESENTED BY: Michigan Thoracic Society

After attending this session, participants will be able to explain how the diagnosis of fibrotic lung disease is made; list the treatment and management techniques used in pulmonary fibrosis including heart-lung transplantation; and recite the connection between occupational health hazards and lung disease as it relates to silicosis.

COURSE DIRECTOR: Steven M. Springer, Chapter Administrator, Michigan Thoracic Society

PRESIDING: Doctor Springer

SPEAKERS: To Be Announced

Recent Advances in Infertility Therapy

PRESENTED BY: Center for Reproductive Medicine, Oakwood Hospital, Dearborn

This course will provide an overview of currently evolving techniques for treatment of female and male infertility. Included will be endoscopic surgery, balloon tuboplasty, conservative treatment of ectopic pregnancy, sterilization reversal, varicocele and subclinical varicocele, electroejaculation, epididymal sperm aspiration, in vitro fertilization with micromanipulation and use of donor gametes.

COURSE DIRECTOR: Maria F. Hayes, MD, Director, Center for Reproductive Medicine, Oakwood Hospital, Dearborn

PRESIDING: Doctor Hayes

SPEAKERS:

Doctor Hayes

"Fallopian Tube Repair 1992"

C. B. Dhabuwala, MD, Associate Professor, Department of Urology, Wayne State University School of Medicine

"New Techniques for Treatment of Male Infertility"

David M. Magyar, DO, Director, Center for Reproductive Medicine, Oakwood Hospital, Dearborn

"In Vitro Fertilization and Its Offshoots"

Emergency Assessment and Management of Acute Cardiac Ischemia

PRESENTED BY: Michigan College of Emergency Medicine and Department of Emergency Medicine, Henry Ford Hospital, Detroit

This course will provide practical information in chest pain decision-making and early management of acute cardiac ischemia. Difficulties in diagnosing cardiac chest pain in the emergency room, as well as recent new tools and perspectives in chest pain decision-making will be emphasized. Non-thrombolytic therapy of cardiac ischemia, such as aspirin, heparin, B-blockers, and antihypertensives will be extensively discussed followed by thrombolytic therapy of acute myocardial infarction in the emergency department.

COURSE DIRECTOR: Lydia L. Baltarowich, MD, FACEP, Senior Staff Physician, Department of Emergency Medicine, Henry Ford Hospital, Detroit; Michigan Academy of Emergency Medicine

PRESIDING: Doctor Baltarowich

SPEAKERS:

Daniel Stewert, MD, FACEP, Assistant Professor, Department of Emergency Medicine, Michigan State University College of Human Medicine

"Early Diagnosis of Chest Pain in the Emergency Department"

Asit Gokli, MD, FACEP, Senior Staff Physician, Department of Emergency Medicine, Henry Ford Hospital, Detroit

"Prehospital Treatment of Acute Cardiac Ischemia"

Christopher Lewandowski, MD, FACEP, Senior Staff Physician, Department of Emergency Medicine, Henry Ford Hospital, Detroit

"Non-Thrombolytic Treatment of Acute Cardiac Ischemia in the Emergency Department"

Bradford Walters, MD, FACEP, Senior Staff Physician, Department of Emergency Medicine, Henry Ford Hospital, West Bloomfield Center

"Emergency Department Thrombolytic Treatment of Acute Cardiac Ischemia"

Wiping out Sinusitis

PRESENTED BY: Department of Otolaryngology, Wayne State University School of Medicine

A state-of-the-art update on the etiology and management of sinusitis. This course, designed for internists, pediatricians, family practitioners, and specialists involved in the diagnosis and treatment of sinusitis, will cover the latest information on the cause, medical therapy and surgical therapy of acute and chronic sinusitis.

COURSE DIRECTOR: Steven C. Marks, MD, Assistant Professor, Department of Otolaryngology, Wayne State University School of Medicine

PRESIDING: Doctor Marks

SPEAKERS:

Doctor Marks

"Anatomy and Physiology of Sinusitis"

Richard Arden, MD, Assistant Professor, Department of Otolaryngology, Wayne State University School of Medicine

"Medical Management of Sinusitis"

Arnold Cohn, MD, Professor, Department of Otolaryngology, Wayne State University School of Medicine

"Allergy Management in Sinusitis"

Doctor Marks

"Surgical Management of Sinusitis"



Computers in Medicine: From Database to Diagnosis, A Hands-on Workshop

PRESENTED BY: Department of Internal Medicine, Oakwood Hospital, Dearborn

This course, through hands-on training using IBM compatible computers will introduce the practicing physician to the power of computers, in medicine. Database management, literature searching, the paperless medical record and medical informatics, as well as word processing capabilities will be demonstrated. Time will be given for participating physicians to explore these programs in a live computer laboratory. Attendance is limited to 15 participants.

COURSE DIRECTOR: Nicholas J. Lekas, MD, Director, Internal Medicine Residency, Oakwood Hospital - Medical Education, Dearborn

PRESIDING: Doctor Lekas

SPEAKERS:

Raphael Kiel, MD, Assistant Director, Internal Medicine Residency Program, Oakwood Hospital - Medical Education, Dearborn

"Literature and Text Searching"

"Use of Differential Diagnosis Programs"

Lyle D. Victor, MD, Director, Transitional Residency, Oakwood Hospital - Medical Education, Dearborn

"Paperless Medical Record and Use of Macros"

Current Issues in the Management of the Menopausal Patient

PRESENTED BY: Department of Obstetrics and Gynecology, Henry Ford Hospital, Detroit

The course will provide practical information about current concepts in the use of hormonal replacement therapy during menopause. Particular emphasis will be given to potential cardiovascular improvement, screening for and prevention of osteoporosis, as well as the risks of hormonal replacement therapy, particularly neoplasia. The course, using a combination of lectures and case discussions, is designed for primary and consulting physicians who manage postmenopausal patients.

COURSE DIRECTOR: Ronald T. Burkman, MD, Chairman, Department of Obstetrics and Gynecology, Henry Ford Hospital, Detroit

PRESIDING: Doctor Burkman

SPEAKERS:

Michael Kleerekoper, MD, Head, Bone and Mineral Division, Henry Ford Hospital, Detroit

"Introduction to the Menopause and HRT"

Michael L. Hicks, MD, Staff Gynecologic Oncologist, Division of Gynecologic Oncology, Henry Ford Hospital, Detroit

"Risks of HRT"

Current Methods of Treating Breast and Prostate Cancer

PRESENTED BY: Departments of Surgery and Urology, William Beaumont Hospital, Royal Oak

The Breast Cancer part of this course will offer basic information on quality and accuracy of diagnostic mammography as well as recommendations concerning scheduling of screening mammography. Additionally, the diagnosis and indications for the various therapeutic modalities, surgery, radiation therapy, and chemotherapy, will be presented. The Prostate portion will clarify for the practitioners the role of digital rectal exam of the prostate gland (DRE), prostate specific antigen (PSA), transrectal prostate ultrasonography (TRUS) and prostate biopsy in screening and diagnosing prostatic cancer.

COURSE CO-DIRECTORS: John A. Ingold, MD, Vice Chief, Department of Surgery, William Beaumont Hospital, Royal Oak and Ananais Diokno, MD, Chief, Department of Urology, William Beaumont Hospital, Royal Oak

PRESIDING: Doctors Ingold and Diokno

SPEAKERS:

Doctor Ingold

"Surgical Options of Lumpectomy, to be followed with Radiation Therapy, vs. Mastectomy"

Frank Viccini, MD, Attending Physician, Department of Radiation Oncology, William Beaumont Hospital, Royal Oak

"Radiation Therapy Following Either Partial or Total Mastectomy"

Freeman Wilner, MD, Chief, Section of Medical Oncology, William Beaumont Hospital, Royal Oak

"Chemotherapy as an Adjunctive Treatment and Palliative Treatment"

Kathy Wimbish, MD, Chief, Section of Mammography, William Beaumont Hospital, Royal Oak

"Review of Mammographic Guidelines and Diagnostic Capability vs. Pitfalls"

Doctor Diokno

"The Role of CRE, PSA and TRUS in Detection of Prostatic Carcinoma"

Continued on following page

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William Spencer, MD, Attending, Department of Urology, William Beaumont Hospital, Royal Oak

"Indications and Results of Radical Prostatectomy on prostate carcinoma patients"

Alvaro Martinez, MD, Chief, Department of Radiation Oncology, William Beaumont Hospital, Royal Oak

"Indications and Results of Radiation Therapy on Patients with Prostate Carcinoma"

Brian Miles, MD, Attending, Department of Urology, William Beaumont Hospital, Royal Oak

"Options for Therapy for Metastatic Prostate Carcinoma"

How to Manage Psychiatric Patients in a World of Shrinking Resources

PRESENTED BY: Department of Psychiatry, Sinai Hospital of Detroit

This course will be aimed at the primary care physician in ambulatory settings. It will cover screening, diagnosis and treatment of patients with 1) insomnia and multiple somatic complaints, 2) "bad nerves" or anxiety, 3) depression, and 4) harmful use of prescription and non-prescription drugs. The participant will learn how to use the CAGE (a screening tool) and the Brief Intervention Treatment Protocol (BITP). In addition, the participant will receive an extensive referral handbook upon completion of this course.

COURSE DIRECTOR: L. S. Hotchkiss, MD, Chairperson, Department of Psychiatry, Sinai Hospital of Detroit

PRESIDING: Doctor Hotchkiss

SPEAKERS: To Be Announced

Identification and Intervention in Family Violence - Focus on Spouse Abuse

PRESENTED BY: MSMS Auxiliary

The course objectives are to increase the awareness levels of physicians and others to the issue of spouse abuse, educate as to guidelines in dealing with spouse abuse, review the reporting and notification requirements when confronted with spouse abuse, and discuss utilization of clearing houses for dissemination of information dealing with this issue.

COURSE DIRECTOR: Thomas C. Payne, MD, MSMS President; Radiologist, Lansing Radiology P.C.

PRESIDING: Rhoda M. Powsner, MD, Washtenaw County Medical Society President; Member AMA Advisory Committee on Family Violence

PANEL SPEAKERS:

Courtney Esposito, Pennington, New Jersey

A. Stuart Hanson, MD, President, Minnesota Medical Association, Minneapolis, MN

Elizabeth Pollard, JD, First Assistant Prosecuting Attorney, Prosecuting Attorney's Office, Ann Arbor

Captain Dan Branson, Ann Arbor Police Department

Doris Suciu, MD, Flint Coalition Against Domestic Violence

Immunization Update - Convention and Controversy

PRESENTED BY: Michigan Chapter, American Academy of Pediatrics

This course will provide primary care physicians with practical information about recent changes in recommended pertussis vaccinations, requirements for a second measles-mumps-rubella vaccine, and new regulations concerning immunization requirements for day care and public school attendance. In addition licensing multiple *Hemophilus Influenza Type B* vaccines with different schedules, and the pros and cons of the hepatitis B universal immunization program for infants will be addressed, concluding with a panel discussion of immunization questions solicited from the audience.

COURSE DIRECTOR: Dennis L. Murray, MD, Professor and Division Director, Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

PRESIDING: Doctor Murray

SPEAKERS:

David Johnson, MD, Chief, Communicable Disease Control, Michigan Department of Public Health

"Role of MDPH in Regulations or Immunizations"

Susan Kessler, MD, Assistant Professor, Department of Pediatric Infectious Diseases, Children's Hospital of Detroit

"Pertussis Vaccine - Whole Cell and Acellular Type"

Janet Gilsdorf, MD, Associate Professor and Division Director, Department of Pediatrics, University of Michigan Medical School

"Hemophilus Influenza Type B Vaccine"

Doctor Murray

"Hepatitis B Vaccine and Universal Immunization"

Office Approach to Cardiac Arrhythmias

PRESENTED BY: Department of Cardiology, William Beaumont Hospital

The course will focus on the evaluation and management of supraventricular arrhythmias, ventricular arrhythmias, and syncope of undetermined origin. The current use of diagnostic studies including electrophysiologic testing, signal averaged electrocardiography, and tilt table testing will be reviewed. New therapeutic modalities including ablation therapy and implanted pacemakers and defibrillators will also be reviewed.

COURSE DIRECTOR: Douglas Westveer, MD, Director of Coronary Care, Department of Cardiology William Beaumont Hospital, Royal Oak

PRESIDING: Doctor Westveer

SPEAKERS: To Be Announced

Rheumatologic Update 1992

PRESENTED BY: Department of Rheumatology, University of Michigan Medical School

This course will offer timely topics in rheumatology for practicing Family Physicians and Internists throughout Michigan including updates on newer nonsteroidals and primary care rheumatologic problems.

COURSE DIRECTOR: Mark A. McQuillan, MD, FACP, Clinical Instructor, Department of Rheumatology, University of Michigan Medical School

PRESIDING: Doctor McQuillan

SPEAKERS:

Diane Trudell, MD, Private Practice, Rheumatology, Flint

"Laboratory Testing in Rheumatic Disease, Parvovirus and Sjogren's Syndrome"

Larry Silverman, MD, Private Practice, Rheumatology, Birmingham

"New Combination Therapies and Immunomodulators in Rheumatic Disease"

Doctor McQuillan

"New Nonsteroidals"

What's New About Alzheimer's Disease

PRESENTED BY: Michigan Alzheimer's Disease Research Center and the Alzheimer's Association, Michigan Council

This course will explain how to recognize dementia and why the accurate diagnosis of Alzheimer's disease is more important than ever. The course will illustrate how the needs of

patients and their families can be met by their physician's and how the developing network of existing services in Michigan can be accessed.

COURSE DIRECTOR: Norman L. Foster, MD, Associate Professor, Department of Neurology, University of Michigan Medical School

PRESIDING: Doctor Foster

SPEAKERS:

Doctor Foster

"What's New about Alzheimer's Disease in Michigan?"

Jerry Stevens, National Field Representative, Alzheimer's Association of Michigan

"What do Patients and Families Want and Need from the Community?"

Margaret Z. Jones, MD, Professor, Department of Pathology, Michigan State University College of Human Medicine

"The Importance of Autopsy to Families of Patients with Dementia"

Matthew Weiss, DO, MPH, Vice President of Geriatric Services, Flint Osteopathic Hospital

"How Practicing Physicians Access Geriatric Assessment Services to Assist Patients"



No Charge for this "Early Bird" Plenary Session

"Ethical Alternatives to Physician-Assisted Suicide"

Continental Breakfast at 7:00 a.m.

Presentation at 7:15 a.m.

Michael Frederick, MD, Medical Director of Hospice of Southern Illinois.

Doctor Frederick will primarily focus on pain management, hospice care and other end-of-life options as alternatives to physician assisted suicide. Make plans now to be a part of this controversial but important issue as MSMS continues to discuss the medical, ethical and political aspects of physician-assisted suicide with Michigan physicians.

Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan College of Emergency Physicians

This course will include lectures and practical situations for teaching Basic Cardiac Life Support according to the American Heart Association guidelines. The practical sessions will include hands-on teaching of cardiopulmonary resuscitation, obstructed airways in unconscious and conscious victims, including infants, and CPR. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Vice Chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing

PRESIDING: Doctor Orr

SPEAKERS:

Greg Baker, BCLS Instructor, East Lansing Fire Department

Glena Christiansen, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Debra Deford, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Laura Lane, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Anthony Meholic, BCLS Instructor, St. Lawrence Hospital, Lansing

Doctor Orr

Cardiovascular Risk Factor in the Diabetic Patient

PRESENTED BY: American Diabetes Association

The focus of this program will be the interrelationship of risk factors associated with diabetic patients. The program will stress the need for aggressive therapeutic efforts directed at obesity, smoking, hypertension, dyslipidemia and NIDDM. Insulin resistance and hyperinsulinemia appear to be integral components of this cluster of risk factors. Upon completion the primary care physician will be able to: List factors associated with the development of cardiovascular disease; Understand the interrelationship that exists between cardiovascular disease risk factors; and establish the need for aggressive therapy in the management of the risk factors which lead to the progressive development of cardiovascular disease.

COURSE DIRECTOR: George Grunberger, MD, Director, Diabetes Program and Professor, Department of Medicine, Wayne State University School of Medicine

PRESIDING: Doctor Grunberger

SPEAKERS:

Aaron Vinik, MD, Professor, Department of Medicine and Director, Diabetes Institute, East Virginia Medical School, Norfolk, Virginia

"Management of CV Risk Factors in Diabetes"

Doctor Grunberger

"Pathophysiology of Syndrome of Risk Factors"

Computers in Medicine: From Database to Diagnosis, A Hands-on Workshop

PRESENTED BY: Department of Internal Medicine, Oakwood Hospital, Dearborn

This course, through hands-on training using IBM compatible computers will introduce the practicing physician to the power of computers in medicine. Database management, literature searching, the paperless medical record and medical informatics, as well as word-processing capabilities will be demonstrated. Time will be given for participating physicians to explore these programs in a live computer laboratory. Attendance is limited to 15 participants.

COURSE DIRECTOR: Nicholas J. Lekas, MD, Director, Internal Medicine Residency, Oakwood Hospital - Medical Education, Dearborn

PRESIDING: Doctor Lekas

SPEAKERS:

Raphael Kiel, MD, Assistant Director, Internal Medicine Residency Program, Oakwood Hospital - Medical Education, Dearborn

"Literature and Text Searching"

"Use of Differential Diagnosis Programs"

Lyle D. Victor, MD, Director, Transitional Residency, Oakwood Hospital - Medical Education, Dearborn

"Paperless Medical Record and Use of Macros"

Current Indication and Results of Total Hip and Total Knee Arthroplasty

PRESENTED BY: Department of Orthopaedic Surgery, Wayne State University School of Medicine

This course will acquaint the primary care physicians with the various types of total hip and knee arthroplasty (cemented, cementless, hybrid, H-A coated prosthesis), their indications, and results. Since many of the failures reflect poor patient selection, a careful review of patient selection criteria and preoperative evaluation will be provided. The indications, surgical techniques, and results of revision total hip and knee arthroplasty will also be detailed.

COURSE DIRECTOR: Robert H. Fitzgerald, MD, Professor and Chairman, Department of Orthopaedic Surgery, Wayne State University School of Medicine

PRESIDING: Doctor Fitzgerald

SPEAKERS:

Doctor Fitzgerald

"Total Hip Arthroplasty: Patient selection and the results of cemented arthroplasties"

John C. Colwill, MD, Orthopaedic Surgery, Blodgett Memorial Hospital, Grand Rapids

"Total Hip Arthroplasty: Modern Prosthetic materials, design, and the results of cementless arthroplasties"

Lawrence G. Morawa, MD, Clinical Associate Professor, Department of Orthopaedic Surgery, Wayne State University School of Medicine

"Total Knee Arthroplasty: Patient selection and the results of cemented arthroplasties"

John Grady-Benson, MD, Orthopaedic Surgeon, University of Michigan Hospital, Ann Arbor

"Total Knee Arthroplasty: Modern prosthetic materials, design, and the results of cementless arthroplasties"

Clinical Dermatology

PRESENTED BY: Michigan Dermatological Society

The clinical evaluation and management of childhood pigmented lesions and cutaneous manifestations of AIDS will be addressed during this course. In addition, an update on cutaneous malignant melanoma will be provided. This course is appropriate for primary care physicians as well as dermatologists and other specialists.

COURSE DIRECTOR: L. Boyd Savoy, MD, Chief, Dermatology Service, Veterans Administration Medical Center, Allen Park

PRESIDING: Doctor Savoy

SPEAKERS:

Benjamin K. Fisher, MD, FRCP, Professor, Department of Dermatology, University of Toronto Medical School and Chief, Division of Dermatology, Wesslesley Hospital, Toronto

"The Skin Manifestations of AIDS"

Mary L. Williams, MD, Associate Professor, Department of Dermatology, University of California/San Francisco and Veterans Administration Medical Center, San Francisco, California

"Pigmented Lesions in Childhood"

Arthur J. Sober, MD, Associate Chief of Dermatology and Associate Professor of Dermatology, Harvard Medical School and Massachusetts General Hospital, Boston, Massachusetts

"Update on Cutaneous Malignant Melanoma"

Flexible Sigmoidoscopy: Indications and Technique

PRESENTED BY: Michigan Society of Gastrointestinal Endoscopy

This course is to assist the primary care physician in the technique of flexible sigmoidoscopy. The indications for this procedure, the controversy of flexible sigmoidoscopy and fecal occult blood (FOB) testing in screening the community population and an overview of colon cancer including genetic factors will be discussed. Representative endoscopic pathology as seen via the sigmoidoscope will be shown. A short video demonstration of the technique will be reviewed. Finally, we will stress the technique with hands on instructions utilizing sigmoidoscopes on rubber models as provided by Olympus Corporation.

COURSE DIRECTOR: Peter H. DeRidder, MD, FACP, FACG, Immediate Past President, Michigan Society of Gastrointestinal Endoscopy

PRESIDING: Doctor DeRidder

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Continued from page 43

SPEAKERS:

Doctor DeRidder

"The Efficacy of Flexible Sigmoidoscopy and Fecal Occult Blood Testing"

Stan Strasias, MD, Member of Board of Trustees, Michigan Society of Gastroenterology

"An Overview of Colon Cancer and Genetics"

Dominic Wong, MD, President, Michigan Society of Gastroenterology

"Screening and Follow Up of High Risk Patients"

Michael C. Dufy, MD, FACP, Member of Board of Trustees, Michigan Society of Gastroenterology

"Endoscopic Pathology of Rectosigmoid Colon"

Identification and Intervention in Family Violence - Focus on Elder Abuse

PRESENTED BY: MSMS Auxiliary

The course objectives are to increase the awareness levels of physicians and others to the issue of elder abuse, educate as to guidelines in dealing with elder abuse, review the reporting and notification requirements when confronted with elder abuse, and discuss utilization of clearing houses for dissemination of information dealing with this issue.

COURSE DIRECTOR: Thomas C. Payne, MD, MSMS President; Radiologist, Lansing Radiology P.C.

PRESIDING: James G. O'Brien, MD, Chairman MSMS Task Force on Aging and AMA Elder Abuse Working Group

PANEL SPEAKERS:

Kay Thiede, MSN, St. Lawrence Hospital

Gloria Thomas, MSW, St. Lawrence Hospital

Jan Basler, Adult Protective Services, Eaton Rapids

Physician-Assisted Suicide: Patient and Physician Perspectives

PRESENTED BY: Genesee County Medical Society Bioethics Committee

This highly-interactive session will explore Physician Assisted Suicide from the perspectives of a medical ethicist, a forensic psychiatrist, and both Right to Life and the Hemlock Society. The forensic psychiatry and ethics presentations will focus on both the patients' and physicians' perspectives, while interest group's perspectives will be policy oriented.

The session will conclude with an interactive panel discussion.

COURSE DIRECTOR: John W. Tauscher, MD, Chairman, Genesee County Medical Society Committee on Bioethics

PRESIDING: Howard Brody, MD, Chairman, Michigan State Medical Society Bioethics Committee

SPEAKERS:

Greg Trianosky, PhD, Associate Professor, Department of Philosophy, University of Michigan - Flint

"Physician-Assisted Suicide, The Ethical Perspective"

Emanuel Tanay, MD, Clinical Professor, Department of Psychiatry, Wayne State University School of Medicine

"Psychiatric Aspects of Physician-Assisted Suicide - The Patient and the Physician"

Janet Good, President, Hemlock Society of Michigan

PANEL MEMBER

Edward L. Rivet, II, MPA, Legislative Director, Right to Life of Michigan

PANEL MEMBER

State of the Art and Future Approaches to Brain Tumors

PRESENTED BY: Department of Neurological Surgery, Wayne State University School of Medicine

This course will familiarize all participants with the concepts of primary brain tumors, benign & malignant, their management and new developments in techniques and chemotherapy. Radiosurgery and computer assisted neurosurgery will be highlighted. A description of pediatric and adult tumor problems will be reviewed.

COURSE DIRECTOR: Fernando G. Diaz, MD, PhD, Professor and Chairman, Department of Neurological Surgery, Wayne State University School of Medicine

PRESIDING: Doctor Diaz

SPEAKERS:

Lucia Zamarano, MD, Chief, Department of Neurosurgery/Oncology, Wayne State University School of Medicine

"Computer Assisted Surgery of Brain Tumors"

Alexa P. Canady, MD, Vice Chief, Department of Neurosurgery, Wayne State University School of Medicine

"Brain Tumors in Children"

Geoffrey Barger, MD, Chief, Department of Medical Neuroncology, Wayne State University School of Medicine

"Chemotherapy in Brain Tumors"

Laurie Gasper, MD, Assistant Professor, Department of Radiation Oncology, Wayne State University School of Medicine.

"New Developments in Radiation Therapy of Brain Tumors"

Allergy/Asthma/Immunology Update - 1992

PRESENTED BY: Michigan Allergy Society

This course will address concerns and proper usage of drugs for allergy and asthma during pregnancy; will discuss current controversies in asthma therapy; and will provide hands-on experience on how nutritional elements influence immunological functions.

COURSE DIRECTOR: Ling T. Shih, MD, President, Michigan Allergy Society

PRESIDING: Doctor Shih

SPEAKERS:

Michael Schatz, MD, Associate Clinical Professor, Department of Medicine and Pediatrics, University of California at San Diego, Kaiser Permanente Medical Center, San Diego

"Management of Asthma & Allergic Rhinitis During Pregnancy"

Elliot F. Ellis, MD, Chief, Department of Allergy/Immunology, Neumours Children's Clinic, Jacksonville, Florida

"Current Controversies in Asthma Therapy"

Robert A. Good, MD, PhD, DSc, Distinguished Graduate Research Professor, Department of Pediatrics, University of South Florida; Head, Department of Allergy and Clinical Immunology, All Children's Hospital, St. Petersburg, Florida

"Influence of Nutrition on Immunological Functions"

Benign Vascular Birthmarks, Psoriasis and Ichthyosis

PRESENTED BY: Michigan Dermatological Society

The goal of this course is to improve management of clinical disorders through improved understanding. Topics for presentation are Benign Vascular Birthmarks, Psoriasis and Ichthyosis.

COURSE DIRECTOR: L. Boyd Savoy, MD, Chief, Dermatology Service, Veterans Administration Medical Center, Allen Park

PRESIDING: Doctor Savoy

SPEAKERS:

Richard J. Phillips, MD, Assistant Professor, Department of Plastic Surgery, Wayne State University School of Medicine and Associate Director, Department of Plastic Surgery, Children's Hospital of Michigan, Detroit

"Assessment and Management of Benign Vascular Birthmarks"

E. William Rosenberg, MD, Professor, Department of Dermatology and Community Medicine, University of Tennessee, Memphis

"Etiology of Psoriasis; Why it Matters"

Mary L. Williams, MD, Associate Professor, Department of Dermatology, University of California/San Francisco and Veterans Administration Medical Center, San Francisco, California

"The Pathogenesis of Ichthyosis or What Makes Scale"

Colorectal Potpourri

PRESENTED BY: Michigan Society of Colorectal Surgeons

The purpose of this half day course is to provide the surgeons, internists, family physicians and other specialty doctors with basic understanding of the most common anorectal diseases of every day practice. In addition, participants will also have the opportunity to acquire the basic techniques of performing certain colorectal procedures.

COURSE DIRECTOR: Che Song Park, MD, President, Michigan Society of Colon and Rectal Surgeons, Saginaw

PRESIDING: Doctor Park

SPEAKERS:

James Lynch, MD, Chief, Division of Colorectal Surgery, William Beaumont Hospital, Troy

"Office Proctology: Diagnosis and Management"

Eric J. Szilagyi, MD, Staff Surgeon, Colorectal Surgery, Henry Ford Hospital, Detroit

"Evaluation and Indications of Local Treatment of Rectal Cancer"

Chairat Chomchai, MD, Staff Surgeon, Colorectal Surgery, Grace Harper Hospital, Detroit

"Options of Local Treatment of Rectal Cancer"

Mark J. Heinzelmann, Staff Surgeon, Colorectal Surgery, Saginaw Cooperative Hospital, Saginaw

"Rectal Prolapse; Different Approaches"



Common Ophthalmic Problems Faced by the Practicing Physician

PRESENTED BY: Kellogg Eye Center, University of Michigan Medical School

This course will emphasize basic clinical management of common ophthalmic problems faced by community physicians. We will emphasize, through lecture and case presentation, the management of the red eye, trauma to the eyes, and the contribution of eye findings to the diagnosis of systemic disease. There will be practical tips on how to examine the eye (including ophthalmoscopy), how to remove a foreign body, how to instill medications, how to patch the eye, and how to manage emergencies.

COURSE DIRECTOR: Jonathan D. Trobe, MD, Professor, Department of Ophthalmology, Kellogg Eye Center, University of Michigan Medical School

PRESIDING: Doctor Trobe

SPEAKERS:

Doctor Trobe

"Introduction to Ophthalmic Problems Including Emergencies"

Mariannette J. Miller-Meeks, MD, Assistant Professor, Kellogg Eye Center, University of Michigan Medical School

"The Red Eye"

C. Christine Nelson, MD, Associate Professor, Department of Eye, Plastic and Orbital Surgery, Kellogg Eye Center, University of Michigan Medical School

"Trauma to the Eyes"

Mark W. Johnson, MD, Assistant Professor, Kellogg Eye Center, University of Michigan Medical School

"The Eyes in Systemic Disease"

Current Issues Relative to Contraception

PRESENTED BY: Department of Obstetrics and Gynecology, Henry Ford Hospital, Detroit; and Michigan Chapter, American College of Obstetricians and Gynecologists

This course, through a combination of lecture and case presentations, will provide primary and consulting physicians with an overview of current contraception issues. Particular emphasis will be given to approaches to contraception for women over the age of 35, as well as providing contraception to the adolescent. New approaches, such as the sub-dermal implants (Norplant) and the new formulations of oral contraceptives will be included in the presentations.

COURSE DIRECTOR: Ronald T. Burkman, MD, Chairman, Department of Obstetrics and Gynecology, Henry Ford Hospital, Detroit

PRESIDING: Doctor Burkman

SPEAKERS:

Doctor Burkman

"Contraception for Women Over 35"

Richard E. Smith, MD, Director, Adolescent Obstetrics and Gynecology, Henry Ford Hospital, Detroit

"Contraception for Adolescent Women"

Hypercoagulability and Hemorrhage: Cost Effective Laboratory Diagnosis and Management

PRESENTED BY: Special Coagulation Center, Michigan State University College of Human Medicine

This course is intended to provide primary and consulting physicians practical information in cost effective laboratory diagnosis and management of platelets, clotting, lysis mechanisms in patients with malignant, infectious, autoimmune, heart, vascular and drug-induced disorders that produce or are associated with thrombosis and bleeding. Information will be presented on hypercoagulability and coumadin necrosis; and on platelet transfusions and ATIII concentrates in DIC. Interpretation of abnormal coagulation testing will be demonstrated by case presentations.

COURSE DIRECTOR: Houria I. Hassouna, MD, PhD, Associate Professor, Department of Medicine, Michigan State University College of Human Medicine

PRESIDING: John A. Penner, MD, FACP, Professor, Departments of Medicine and Pathology, Michigan State University College of Human Medicine

SPEAKERS:

Doctor Penner

"ATIII Concentrates in DIC - Platelet Transfusions in Coagulation Disorders"

Charles Eby, MD, Instructor, Department of Pathology, Washington University Medical School, St. Louis, Missouri

"Hypercoagulability and Coumadin Necrosis"

Cynthia Boynton, MD, Resident, Department of Internal Medicine, Michigan State University College of Human Medicine

"Case Presentations: Interpretation of Abnormal Coagulation Testing"

Doctor Hassouna

"Case Presentations: Significance of Prolonged PT and APTT"

Life and Death Issues of The Sandwich Generation

PRESENTED BY: MSMS Committee on Concerns of Women Physicians

As the population ages, more and more patients are being caught in the middle: still providing care to their children, but also taking on the care of their elderly parents. This course will identify demographics and trends of this "Sandwich Generation," provide resources to assist caregivers, and address how physicians can assist in the life and death decisions that must be made. In addition, methods for identification and treatment of stress illnesses that can occur, will be presented through case presentations.

COURSE DIRECTOR: Martha L. Gray, MD, Ann Arbor, Chairman MSMS Committee on Concerns of Women Physicians

PRESIDING: Doctor Gray

SPEAKERS:

Joyce Hunt, Benefits Specialist, Area Agency on Aging 1-B

"The Sandwich Generation - How it Affects You as a Physician"

Cassandra Klyman, MD, Assistant Clinical Professor, Department of Psychiatry, Wayne State University School of Medicine

"Decisions for Patients Who Need Care"

Mary Elizabeth Roth, MD, Chairperson, Department of Family Practice, Providence Hospital, Southfield

"Decisions for Patients Who are Caregivers"

Pediatric and Adolescent Athletic Injuries

PRESENTED BY: Department of Pediatric Orthopaedics, Wayne State University School of Medicine

At the conclusion of the course, the primary care physician will be able to: Understand the pathophysiology of sports injuries in the skeletally immature athlete; Recognize common pediatric orthopaedic sports injuries; and Formulate appropriate treatment plans for such injuries.

COURSE DIRECTOR: Carl L. Stanitski, MD, Chief, Department of Orthopaedic Surgery, Children's Hospital of Michigan, Detroit

PRESIDING: Doctor Stanitski

SPEAKERS:

Doctor Stanitski

"Overuse Problems"

Deborah F. Bell, MD, Associate Chief, Department of Orthopaedic Surgery, Children's Hospital of Michigan, Detroit

"Cervical Spine Disorders"

Doctor Stanitski

"Back Pain"

Peter J. Spohn, MD, Attending Physician, Department of Orthopaedic Surgery, Children's Hospital of Michigan, Detroit

"Fractures and Their Sequelae"

Doctor Stanitski

"Acute Knee Injuries"

Radiology for Clinicians

PRESENTED BY: Michigan Radiological Society and Department of Radiology, Wayne State University School of Medicine

The course will consist of four presentations dealing with the radiological evaluation of jaundice and scintigraphic (Nuclear Medicine) evaluation for infectious and coronary artery diseases. In addition, the utility of ultrasonography in the evaluation of carotid arterial disease and lower extremity venous thrombosis will be discussed.

COURSE DIRECTOR: A. P. Zingas, MD, FACR, Associate Professor, Department of Radiology, Wayne State University School of Medicine

PRESIDING: Doctor Zingas

SPEAKERS:

Lawrence Davis, MD, Assistant Professor, Department of Radiology, Wayne State University School of Medicine

"Nuclear Medicine in Infectious Disease"

Myer Roszler, MD, Assistant Professor, Department of Radiology, Wayne State University School of Medicine

"Radiologic Evaluation of Jaundice"

Beatrice Madrazo, MD, Radiologist, Department of Radiology, William Beaumont Hospital, Royal Oak

"Ultrasonography for Carotid Arterial Disease and Venous Thrombosis"

Doctor Davis

"Nuclear Cardiology"



No Charge for this "Early Bird" Plenary Session

"Controversial Issues in the Management of Breast Cancer"

Continental Breakfast at 7:00 a.m.

Presentation at 7:15 a.m.

Alexander J. Walt, MB, ChB and Distinguished Professor of Surgery at Wayne State University

This presentation, "Controversial Issues in the Management of Breast Cancer" will include the latest information regarding the use of tamoxifen, and the management of pregnancy and estrogen therapy after breast cancer. Doctor Walt will provide an excellent clinical update to the personal issues addressed by Ann Jillian during her Tuesday evening presentation.

A Day in the Office with Your Cardiac Patients

PRESENTED BY: Michigan Chapter, American Heart Association

This course will present current approaches to common clinical problems in cardiac patients and give guidelines for initiating and monitoring therapy. Topics to be discussed specifically include: HyperLipidemia, Chest Pain, PVC's, Hypertension and Syncope.

COURSE DIRECTOR: Robert Levin, MD, Director, Coronary Care Unit, William Beaumont Hospital, Royal Oak

PRESIDING: Doctor Levin

SPEAKERS:

Doctor Levin

"Current Office Management of Congestive Heart Failure"

Steven Almany, MD, Staff Cardiologist, Department of Cardiology, William Beaumont Hospital, Troy

"Preoperative Cardiac Evaluation for Non-Cardiac Surgery"

Charles Lucas, Departments of Nutritional Medicine and Internal Medicine, William Beaumont Hospital, Royal Oak

"Overview: Office Management of Lipid Disorders"

Charles Webb, MD, Director, Electrophysiology Service, Department of Cardiology, Henry Ford Hospital, Detroit

"Approach to the Patient with Ventricular Arrhythmia"

Alternatives for Breast Reconstruction

PRESENTED BY: Michigan Academy of Plastic Surgeons

The investigation of silicone gel breast prostheses has resulted in the removal for practical purposes of the products from the market with the loss of one major method of breast reconstruction following mastectomy. This course will review the current status of breast implants, tissue expansion and flap reconstruction techniques. This course is directed to plastic surgeons and residents.

COURSE DIRECTOR: Donald M. Ditmars, Jr., MD, Division Head, Plastic Surgery, Henry Ford Hospital, Detroit

PRESIDING: Doctor Ditmars

SPEAKERS:

Michael Schenden, MD, Assistant Clinical Professor, Department of Plastic and Reconstructive Surgery, Wayne State University School of Medicine

"Update on the Legal Status of Breast Prostheses"

John Gibney, MD, Affiliate, Plastic and Reconstructive Surgery, Scottsdale Memorial Hospital, Scottsdale, Arizona

"Breast Reconstruction Using Tissue Expansion"

Herman P. Houin, MD, Senior Staff Surgeon, Department of Plastic and Reconstructive Surgery, Henry Ford Hospital, Detroit

"Secondary Procedures Following TRAM Flap Breast Reconstruction"

Michael Schenden, MD, Assistant Clinical Professor, Department of Plastic and Reconstructive Surgery, Wayne State University School of Medicine

"Alternatives in Implant Breast Reconstruction"

Basic Cardiac Life Support

PRESENTED BY: St. Lawrence Hospital and Michigan College of Emergency Physicians

This course will include lectures and practical situations for teaching Basic Cardiac Life Support according to the American Heart Association guidelines. The practical sessions will include hands-on teaching of cardiopulmonary resuscitation, obstructed airways in unconscious and conscious victims, including infants, and CPR. A BCLS card or Heart Saver card will be presented upon completion of the course.

COURSE DIRECTOR: Robert K. Orr, Jr., DO, Vice Chief, Department of Emergency Medicine, St. Lawrence Hospital, Lansing

PRESIDING: Doctor Orr

SPEAKERS:

Greg Baker, BCLS Instructor, East Lansing Fire Department

Glena Christiansen, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Debra Deford, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Laura Lane, RN, BCLS Instructor, St. Lawrence Hospital, Lansing

Anthony Meholic, BCLS Instructor, St. Lawrence Hospital, Lansing

Doctor Orr

Current Approaches to the Management of the Obese Patient

PRESENTED BY: Department of Endocrinology, University of Michigan Medical School

This course will review current concepts of the pathophysiology and medical complications of obesity, guidelines for safe weight loss, strategies for developing an effective weight loss program and the place of surgical management in the treatment of patients with morbid obesity. Selected cases will be discussed by the course faculty and the audience will be encouraged to present their own cases for discussion.

COURSE DIRECTOR: David E. Schteingart, MD, Professor, Department of Internal Medicine, University of Michigan Medical School

PRESIDING: Doctor Schteingart

SPEAKERS:

Doctor Schteingart

"Selection of a Management Program for Obese Patients"

Judy Tomer, RD, Dietitian, Department of Nutrition, University of Michigan Hospitals

"Nutritional Management of Patients in a Weight Reduction Program"

Denise Marecki, RD, Research Dietitian, Clinical Research Center, University of Michigan Hospitals

"The Use of Very Low Calorie Diets in the Management of Morbid Obesity"

Richard M. Lampman, PhD, Adjunct Associate Professor, Department of Exercise Physiology, University of Michigan

"Exercise Prescription in the Management of Obesity"

Gloria J. Edwards, PhD, Chief Social Worker, University of Michigan

"Psychosocial Evaluation and Management of Obese Patients"

Laparoscopic Surgery: Pros and Cons

PRESENTED BY: Michigan Chapter, American College of Surgeons

This course will cover up-to-date knowledge on laparoscopic procedures being performed, pro and cons will be discussed in great length. Participants will become knowledgeable about indications, contraindications, complications, and benefits of such procedures.

COURSE CO-DIRECTORS: Krishna K. Sawhney, MD, FACS, Clinical Associate Professor, Department of Surgery, Wayne State University School of Medicine; and Larry Lloyd, MD, FACS, Chief, Department of Surgery, St. John Hospital, Detroit

PRESIDING: Doctors Sawhney and Lloyd

SPEAKERS:

Robert Elkus, MD, Senior Staff Surgeon, Department of Surgery, Henry Ford Health System, Detroit

"Laparoscopic Cholecystectomy: Is it Safe? Is it Better?"

Doctor Lloyd

"Laparoscopic Hernia Repair: Pros & Cons"

Ali Mehram, MD, Senior Staff Surgeon, Department of Obstetrics and Gynecology, Oakwood Hospital, Dearborn

"Laparoscopic Assisted Hysterectomy: Indications and Complications"

J. B. Smith, MD, Associate Professor, Departments of Surgery and Urology, Wayne State University School of Medicine

"Laparoscopic Urological Surgical Procedures: Present & Future"

Donald Weaver, MD, Associate Professor, Department of Surgery, Wayne State University School of Medicine

"Beyond Laparoscopic Cholecystectomy Newer Procedure: Where are we going?"

Learning Disabilities in Children

PRESENTED BY: Michigan Academy of Family Physicians

This course will provide pediatricians, family physicians and child psychologists with a knowledge of various learning disorders. The description, differential diagnosis and assessment of various types of learning disorders will be followed by a discussion of interventions relevant to the development of social, emotional and academic competency in the learning disabled child.

COURSE DIRECTOR: Miriam S. Daly, MD, Private Practice, Albion; Michigan Academy of Family Physicians

PRESIDING: Doctor Daly

Continued on following page

SPEAKERS:

Daniel Nolan, PhD, Child Psychologist, Ann Arbor

Marsha Rapley, MD, Assistant Professor, Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

Occupational Skin Disease

PRESENTED BY: Michigan Occupational and Environmental Medical Association

This course, through lectures and panel discussions, will instruct primary and occupational medicine physicians, as well as general dermatologists, in the vast array of cutaneous abnormalities that are primarily caused or aggravated by the workplace environment (common chemical and physical exposures). Participants will become familiar with an approach to these skin disorders, both diagnostically and therapeutically, as well as be introduced to preventive and control strategies. This course will cover occupational contact dermatitis, patch testing, the role of atopy, occupational skin cancer, occupational leukoderma, infections, and aggravation of non-occupational skin diseases. The role of prevention will be emphasized.

COURSE DIRECTOR: Thomas Hal Morley, MD, MPH, Michigan Occupational Medical Association

PRESIDING: Doctor Morley

SPEAKERS:

Donald J. Birmingham, MD, Department of Dermatology, Wayne State University School of Medicine and University of Michigan Medical School

Peter J. Aronson, MD, Assistant Professor, Department of Dermatology, Wayne State University School of Medicine

Harold Plotnick, MD, Clinical Professor, Department of Dermatology, Wayne State University School of Medicine

Sports Medicine: Primary Care Issues

PRESENTED BY: Department of Family Practice, Michigan State University College of Human Medicine and Sports Medicine

This course will assist physicians who take care of athletes address the problem of hypertension, HIV infection, performance enhancement, and steroid abuse. Each 45-minute lecture will review the most current issues and provide practical guidelines for dealing with some of the special needs of athletes.

COURSE DIRECTOR: Henry C. Barry, MD, Assistant Professor, Department of Family Practice, Michigan State University College of Human Medicine

PRESIDING: Doctor Barry

SPEAKERS:

Randolph Pearson, MD, Assistant Professor, Department of Family Practice, Michigan State University College of Human Medicine and Team Physician, Michigan State University "Hypertension and Sports"

David O. Hough, MD, Professor, Department of Family Practice and Director, Department of Sports Medicine, Michigan State University College of Human Medicine

"HIV and the Athlete"

Margot Putukian, MD, Sports Medicine Fellow, Sports Medicine Clinic, Michigan State University College of Human Medicine and Sports Medicine

"Enhancing Athletic Performance"

Kenneth D. Stringer, MD, Associate Professor, Department of Pediatrics, Michigan State University College of Osteopathic Medicine and Team Physician, Michigan State University

"Steroid Use Among Athletes"

The Clinical Approach to Diseases of the Esophagus

PRESENTED BY: Michigan Society of Thoracic and Cardiovascular Surgeons

Diseases of the esophagus will be presented from the viewpoint of the primary care physician. The spectrum of esophageal diseases will be covered including hiatal hernia with reflux esophagitis, esophageal cancer, Zenker's diverticulae, congenital defects and motility disorders. State of the art diagnostic and management methods will be reviewed.

COURSE DIRECTOR: Allen Silbergleit, MD, PhD, Clinical Professor, Department of Surgery, Wayne State University School of Medicine; Director, Department of Surgery, St. Joseph Mercy Hospital, Pontiac; and Michigan Society of Thoracic and Cardiovascular Surgeons

PRESIDING: Doctor Silbergleit

SPEAKERS:

Doctor Silbergleit

"Overview on Common and Uncommon Diseases of the Esophagus"

Elliott Fraiberg, MD, Chief, Division of Gastroenterology, St. Joseph Mercy Hospital, Pontiac

"Initial Approach and Workup for Esophageal Lesions"

Joseph Lewis, MD, Senior Staff Surgeon, Division of Thoracic & Cardiovascular Surgery, Henry Ford Hospital, Detroit, University of Michigan Medical School

"Management of Cancer of the Esophagus"

Clinical Applications of Positron Emission Tomography (PET)

PRESENTED BY: Michigan College of Nuclear Medicine Physicians

This course is intended for primary care physicians who wish to learn which of their patients would benefit from PET Diagnostic studies. The Cardiac, Neurologic, and Oncologic Applications of this technique will be discussed through a lecture format. At the end of the course, the attendee will know the clinical indications, advantages, and disadvantages of PET.

COURSE DIRECTOR: John E. Freitas, MD, Staff Physician, Department of Radiology, St. Joseph Mercy Hospital, Ann Arbor

PRESIDING: Doctor Freitas

SPEAKERS:

Doctor Freitas

"Cardiac Applications of PET"

Kirk A. Frey, MD, PhD, Assistant Professor, Department of Internal Medicine and Neurology, University of Michigan Medical Center

"Neurologic Applications of PET"

Richard L. Wahl, MD, Professor, Department of Internal Medicine and Radiology, University of Michigan Medical Center

"Oncologic Applications of PET"

Complications and Side Effects of Commonly Used Cardiovascular Drugs

PRESENTED BY: Michigan Chapter, American Heart Association

This course will review the incidence, nature, and relative severity of adverse effects associated with commonly used cardiovascular drugs, including antiarrhythmic agents, digoxin, antihypertensive agents, beta-blockers, and calcium channel blockers. The time of onset, duration, and degree of reversibility of these drug-induced complications will be discussed, and strategies for prevention and management will be reviewed.

COURSE CO-DIRECTORS: Charles E. Webb, MD, Director, Cardiac Electrophysiology Laboratory, Henry Ford Hospital and University of Michigan Medical School; James E. Tisdale, PharmD, Assistant Professor, Wayne State University College of Pharmacy and Allied Health Professions

PRESIDING: James E. Tisdale, PharmD

SPEAKERS:

Mihai Gheorghiadu, MD, Professor, Department of Medicine, Northwestern University, Chicago, Illinois

"Prevention, Detection and Management of Toxicity Associated with Digoxin"

Richard Dettloff, PharmD, Assistant Professor of Clinical Pharmacy, Ferris State University College of Pharmacy

"Antihypertensive-Induced morbidity"

Maureen Smythe, PharmD, Assistant Professor, College of Pharmacology and Allied Health Professions, Wayne State University

"Adverse Effects Associated with Beta-Blockers and Calcium Channel Blockers"

Doctor Tisdale

"Antiarrhythmic Drugs: The Good, the Bad, and the Ugly"

Physical Activity and the Elderly

PRESENTED BY: Department of Family Practice, MSU College of Human Medicine

Physicians who care for the elderly will learn how to address the unique problems of the active elderly and the frail elderly. Upon completion of this course, the participant should be able to assist their elderly patients develop rational and safe exercise guidelines that will enhance their functional status.

COURSE DIRECTOR: Henry C. Barry, MD, Assistant Professor, Department of Family Practice, Michigan State University College of Human Medicine

PRESIDING: Doctor Barry

SPEAKERS:

Scott Eathorne, MD, Sports Medicine Fellow, Departments of Family Practice and Sports Medicine, Michigan State University College of Human Medicine

"Exercise Prescriptions for the Elderly"

Jeffrey S. Monroe, ATC, Head Trainer, Department of Intercollegiate Athletes, Michigan State University College of Human Medicine

"Sports, Rehabilitation, and the Elderly"

Douglas B. McKeag, MD, Professor, Department of Family Practice, Michigan State University College of Human Medicine and Team Physician, Michigan State University

"Osteoarthritis, Exercise, and the Older Individual"

Doctor Barry

"Physical Activity and the Frail Elderly"

Prevention of Adult Diseases

PRESENTED BY: Department of Pediatrics, Children's Hospital of Michigan

This course will deal with four disease groups seen in chil-

Continued on following page

Continued from page 41

dren that significantly impact the health of adults: diabetes in childhood, coronary artery disease, eating disorders, and hypertension. These disorders will be discussed from the perspective of their management in childhood and how the impacting of the risk factors associated with these diseases might prevent or control their progression in adulthood.

COURSE DIRECTOR: Alan B. Gruskin, MD, Pediatrician-in-Chief, Department of Pediatric Nephrology, Children's Hospital of Michigan

PRESIDING: Doctor Gruskin

SPEAKERS:

James Gutai, MD, Director, Department of Pediatric Endocrinology, Children's Hospital of Michigan, Detroit

"Prevention of Complications of Juvenile Diabetes Mellitus"

Doctor Gruskin

"Hypertension: Pathophysiology, Treatment, and Risk Factors"

Arthur Robin, PhD, Director, Department of Pediatric Psychology, Children's Hospital of Michigan, Detroit

"Eating Disorders in Childhood: Implications in Adulthood"

Stephen Paridon, MD, Director, Exercise Physiology Lab, Children's Hospital of Michigan, Detroit

"Coronary Artery Disease Prevention and Risk Factors"

Psychiatric Concepts: An Update

PRESENTED BY: Michigan Psychiatric Society

This course will deal with three psychiatric problems which commonly confront the non-psychiatric physician; Depression and its treatment; Somatization; and Panic and generalized anxiety. Diagnostic and therapeutic issues will be addressed.

COURSE DIRECTOR: Oliver Cameron, MD, Associate Professor and Associate Chair, Department of Psychiatry, University of Michigan Medical School; Michigan Psychiatric Society

PRESIDING: Doctor Cameron

SPEAKERS:

Randall Christenson, MD, Director of Older Adult Programs, Pine Rest Christian Hospital; Michigan Psychiatric Society

"Depression in the Elderly and Treatment Choices"

Philip Veenhuis, MD, Chairman, Department of Psychiatry, Providence Hospital, Southfield; Michigan Psychiatric Society

"Psychosomatic Disorders, Somatopsychic Disorders, Somatoform Disorders"

Doctor Cameron

"Panic and Anxiety"

Selected Topics in Plastic Surgery

PRESENTED BY: Michigan Academy of Plastic Surgeons

Clinical and research topics will be presented by the Plastic Surgery and Hand Surgery staff of the Henry Ford Medical Group and our invited guest, Dr. John Gibney, Scottsdale Arizona. Clinical reviews of experiences with chest reconstruction, innovations in techniques for hand fractures and carpal tunnel releases, and experimental muscle tissue expansion will be explored. This course is directed to hand and plastic surgeons and residents in training.

COURSE DIRECTOR: Donald M. Ditmars, Jr., MD, Division Head, Division of Plastic and Reconstructive Surgery, Henry Ford Hospital, Detroit

PRESIDING: Doctor Ditmars

SPEAKERS:

Vigen B. Darian, MD, Senior Staff Surgeon, Department of Plastic and Reconstructive Surgery, Henry Ford Hospital, Detroit

"Henry Ford Experience with Chest Wall Reconstruction"

Herman P. Houin, MD, Senior Staff Surgeon, Department of Plastic and Reconstructive Surgery, Henry Ford Hospital, Detroit

"Fleur-de-lis Flap Breast Reconstruction"

John Gibney, MD, Affiliate, Department of Plastic and Reconstructive Surgery, of Scottsdale Memorial Hospital, Scottsdale, Arizona

"Muscle Transformation and Tissue Expansion for Creation of a Dynamic Pump"

Peter K. Janevski, MD, Senior Staff Surgeon, Department of Hand and Microsurgery, Henry Ford Hospital, Detroit

"Absorbable Suture Repair of Spiral Hand Fractures"

Doreen L. Ganos, MD, Senior Staff Surgeon, Department of Plastic and Reconstructive Surgery, Henry Ford Hospital, Detroit

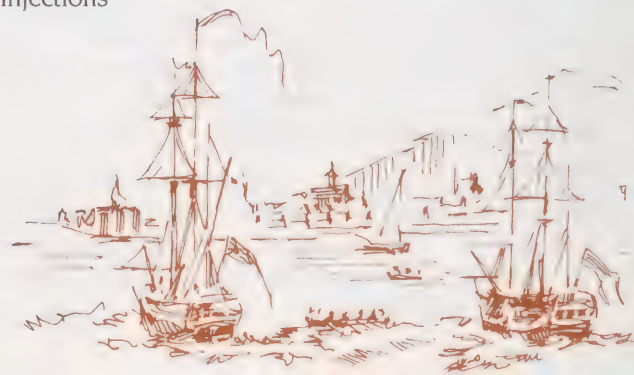
"Wrist Arthroscopy in Chronic Wrist Pain"

Alex P. Kelly, MD, Senior Staff Surgeon, Department of Plastic and Reconstructive Surgery, Henry Ford Hospital, Detroit

"Transverse Wrist Incision for Carpal Tunnel Release"

Doctor Ditmars

"Control of Peyronie's Disease with Percutaneous Steroid Injections"



Treatment of the Injured Worker

PRESENTED BY: Michigan Academy of Physical Medicine and Rehabilitation

The course will cover four occupational health issues facing industrial clients today and in the future. These topics are, Americans with Disabilities Act, evaluation and treatment of low back disorders, cumulative trauma disorders, and objective return to work criteria. The goal is to enlighten primary care physician as to the "hot" issues facing patients in their work place.

COURSE DIRECTOR: Steve Hinderer, MD, Michigan Academy of Physical Medicine and Rehabilitation

PRESIDING: Doctor Hinderer

SPEAKERS:

Ed Trachtman, DO, Medical Director, Occupational Rehabilitation Services, Rehabilitation Institute of Michigan, Detroit

Steven Geiringer, MD, Medical Director, Outpatient Services, Rehabilitation Institute of Michigan, Detroit

John Bernick, MD, Medical Director, Mazda Manufacturing Motor Company, Flat Rock

Mark Upfal, MD, MPH, Medical Director, Occupational Health Services, Detroit Medical Center, Detroit

Classic But Unusual Endocrine Diseases

PRESENTED BY: Division of Endocrinology and Metabolism, Henry Ford Hospital, Detroit

The objective of this course is to inform physicians, by seminar and case presentations, about suspecting, diagnosing, and treating Cushing's syndrome, primary aldosteronism, acromegaly, and prolactinoma.

COURSE DIRECTOR: Max Wisgerhof, MD, Senior Staff Physician, Division of Endocrinology and Metabolism, Henry Ford Hospital, Detroit

PRESIDING: Doctor Wisgerhof

SPEAKERS:

M. Saeed Zafar, MD, Senior Staff Physician, Division of Endocrinology and Metabolism, Henry Ford Hospital, Detroit

"Cushing's Syndrome"

Ved V. Gossain, MD, Professor, Department of Medicine, Michigan State University College of Human Medicine

"Primary Aldosteronism"

Ariel Barkan, MD, Associate Professor, Department of Medicine, University of Michigan Medical School

"Acromegaly"

Luis F. Ospina, MD, Chairman, Department of Endocrinology, William Beaumont Hospital, Troy

"Prolactinoma"

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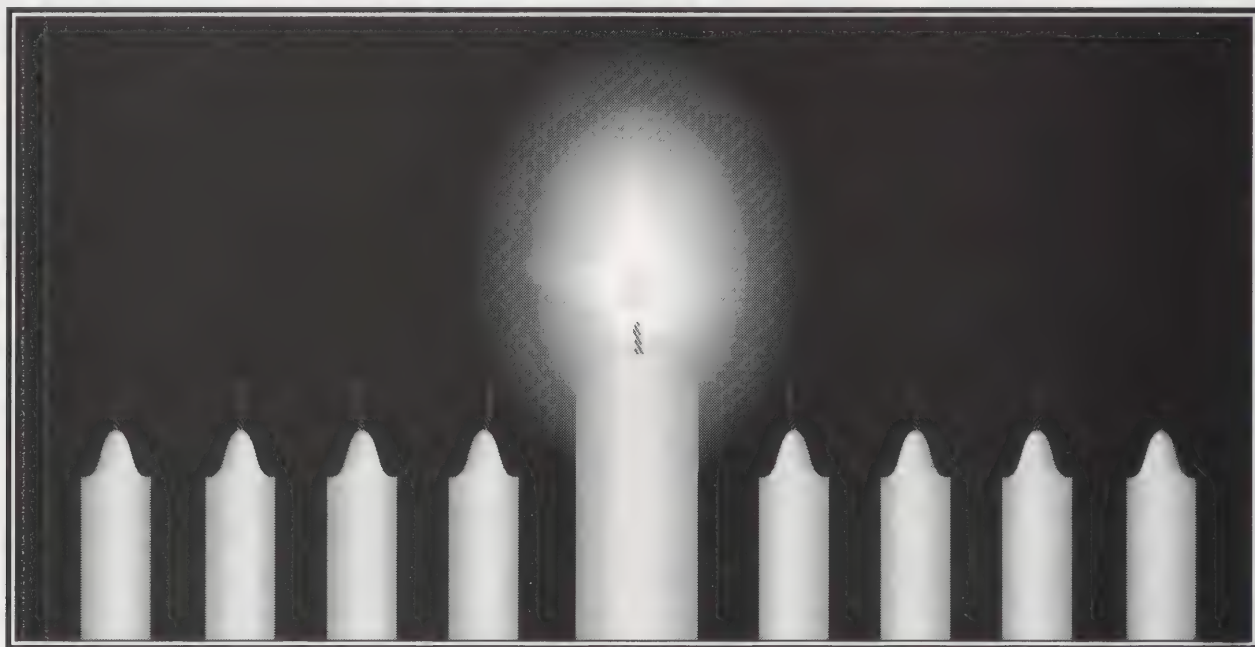
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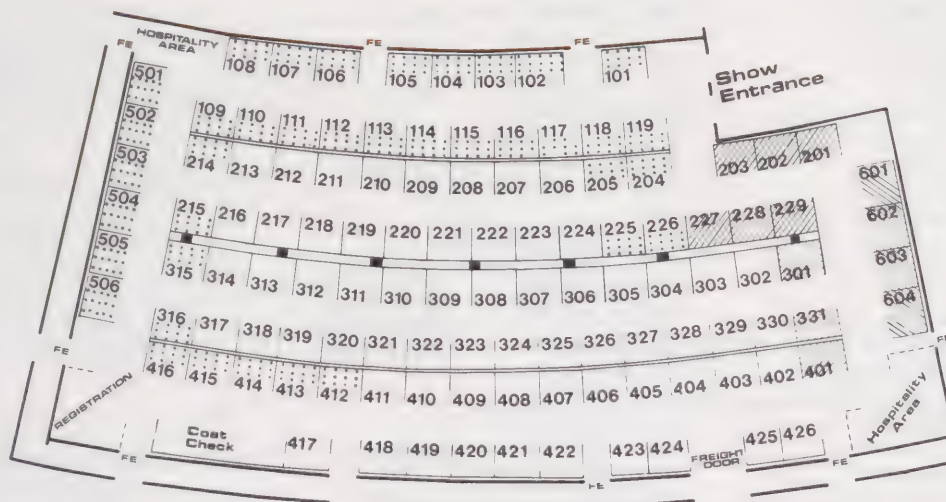


EXHIBIT HOURS

Tuesday, November 17

- 7:30 a.m. - 5:00 p.m. Registration and Exhibits Open to Physicians and Guests
Complimentary Exhibit Hall Passes Available
- 5:00 p.m. - 6:00 p.m. Physician Reception sponsored by 1992 Exhibitors;
Daily Doorprize Winners Announced

Wednesday, November 18

- 7:30 a.m. - 5:00 p.m. Registration and Exhibits Open to Physicians and Guests
Complimentary Exhibit Hall Passes Available
- 5:00 p.m. - 6:00 p.m. Physician Reception sponsored by 1992 Exhibitors;
Daily Doorprize Winners Announced

Thursday, November 19

- 7:30 a.m. - 3:30 p.m. Registration and Exhibits Open to Physicians and Guests
Complimentary Exhibit Hall Passes Available

Coffee

Coffee will be available during the hours of the Exhibit Center, compliments of the Exhibitors and provided by the Michigan Society of Medical Assistants.

Dessert/Activities

A Deli lunch will be held from 11:45 a.m. - 1:00 p.m. in the Hubbard Ballroom on all three days. Dessert and coffee will be served in the Exhibit Center. A schedule of events will be provided with registration materials and will be announced at each day's luncheon.

Daily Doorprize Winners will be announced during the luncheon.

Receptions

Refreshments will be served during Tuesday and Wednesday's Physician Receptions held in the Great Lakes Exhibit Center. Daily Doorprize Winners also will be announced.

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MSMS extends its appreciation to these exhibitors for their financial contribution to the meeting. Exhibitors may conduct daily door prize drawings to encourage physicians to visit their booth. A complete listing of exhibitors and their door prizes will be included in your registration materials.

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Booth 426

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Booth 317

This exhibit is for the purpose of acquainting physicians with the Social Security Disability Program. We dispense pertinent handouts which will be helpful in evaluation of disabled patients who may meet governmental requirements for disability benefits.

Discover Card

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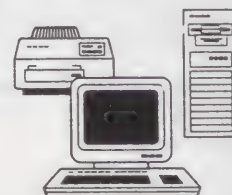
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Michigan Alzheimer's Disease Research Center
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Michigan Chapter, American College of Surgeons
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Michigan Dermatological Society
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Michigan Society of Colorectal Surgeons
Michigan Society of Gastrointestinal Endoscopy
Michigan Society of Thoracic and Cardiovascular Surgeons
Michigan Thoracic Society
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MSMS Auxiliary
MSMS Committee on Aging
MSMS Committee on Concerns of Women Physicians
MSMS Task Force on Environmental Health

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Special Coagulation Center
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Department of Neurosurgery
Department of Rheumatology
Division of Cardiology
Kellogg Eye Center
Wayne State University School of Medicine
Department of Neurological Surgery
Department of Orthopaedic Surgery
Department of Otolaryngology
Department of Pediatric Orthopaedics
Department of Radiology
Department of Surgery

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Department of Emergency Medicine
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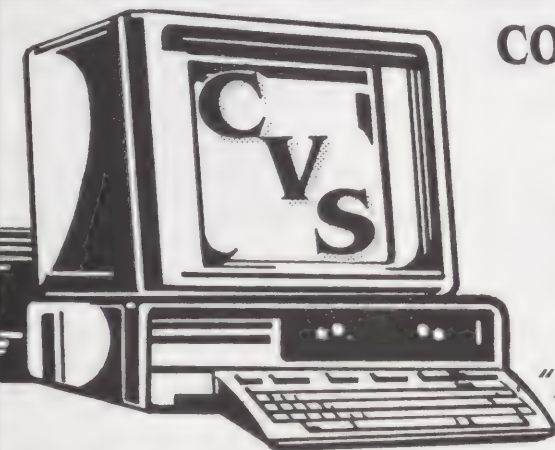
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Tuesday, November 17
Insurance Processing and Coding
8:30 a.m. - 5:00 p.m.

Learn how insurance works - what you need to know to get paid by today's health

care insurers. This program also will address claims processing and follow-up, how RBRVS and the changes that come with it will affect your claims, and how CPT-4 and ICD-9 codes affect your reimbursement. Bring your 1992 CPT Manual.

Wednesday, November 18
ICD-9 Coding for Doctors' Offices
8:30 a.m. - 5:00 p.m.

An in-depth look the ICD-9 system - what's the quickest and surest way to find the right code? When to use fourth and fifth digits and V codes? This program will explore common coding errors and how you can avoid them, as well as Medicare coding and reporting guidelines and how they affect your reimbursement. Bring Volumes 1 and 2 of the current edition of ICD-9.

Thursday Morning, November 19
CPT Coding for Doctors' Offices
8:30 a.m. - 12:00 Noon

Review the new "Evaluation and Management" codes and how they work. What do the new definitions mean to your practice? How can the misuse of codes increase the possibility of an audit? This program will discuss coding procedures, use of modifiers, and how to complete claim forms to maximize your reimbursement. Bring your 1992 CPT Manual.

Thursday Afternoon, November 19
Medical Collections Management
1:00 p.m. - 5:00 p.m.

Learn how to develop a collections policy, how to better handle delinquent patient accounts, and how to educate patients on your payment policies without turning them away from your practice. This program will also discuss specific collection techniques and the legal aspects of collecting.

Friday, November 20
The Business Side of Medicine
8:30 a.m. - 5:00 p.m.

An overview of various aspects of the business of medicine, including personnel management, telephone management, appointment scheduling and financial management. This program will cover what you need to know about job descriptions, employee records, salary administration, telephone etiquette, documenting in medical charts, tips for minimizing patient and physician waiting time, and internal controls for accounts receivable and payable.

Presented by AMA Financing and Practice Services

NOTE: Complimentary Exhibit Hall passes may be obtained at the MSMS registration desk.

You may also purchase optional luncheon tickets at MSMS registration desk.

Medical Office Staff Series November 17 - 20, 1992 Hyatt Regency, Dearborn

Workshop	MSMS Members	Each Additional	Non Members	Each Additional
Tues. Ins. Processing & Coding	\$195	\$156	\$225	\$180
Wedn. ICD-9 Coding	\$195	\$156	\$225	\$180
Thur. am CPT Coding	\$140	\$112	\$160	\$128
Thur. pm Collections Management	\$140	\$112	\$160	\$128
Fri. The Business Side of Medicine	\$195	\$156	\$225	\$180

Please note that multiple attendee discounts are available only when two or more people from the same practice attend the same workshop.

Workshop	Date	Fee
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

Telephone Registration (517) 336-5784 FAX Registration (517) 336-5797

___ Total Course Fee = _____
___ Luncheon Tickets (\$12 each) = _____
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Registration Form

1992 MSMS Annual Scientific Meeting • November 17, 18 & 19 • Hyatt Regency Dearborn

Physicians must make their own hotel reservations prior to 10/16, 1992 directly with the Hyatt Regency Dearborn at 313/593-1234.

Name _____
(please print) (first) (initial) (last)

Street _____

City _____ State _____ Zip _____

County _____ Phone () _____ Previous attendee? ☐ Yes ☐ No

MSMS Member: ☐ Yes ☐ No ☐ Resident ☐ Specialty _____ ☐ Other _____

Adopt-a-Doctor Discount*

Take one-third off your registration fee if you bring a physician who has never attended (or if you have never attended) an MSMS Annual Scientific Meeting.

Your "adopted doctor" is:

Choosing your courses: Please indicate a *first and second* choice - attendance is limited.

Tuesday Morning, November 17

(8:30 a.m. to Noon, including break)

- _____ Basic Cardiac Life Support
- _____ Clinical Issues in AIDS/HIV Management
- _____ Great Lakes Water Quality
- _____ Family Violence - Focus on Child Abuse
- _____ Multi-Disciplinary Management of the Chronic Pain Patient
- _____ Pulmonary Fibrosis
- _____ Recent Advances in Infertility Therapy
- _____ Emergency Assessment and Management of Acute Cardiac Ischemia
- _____ Wiping out Sinusitis

Tuesday Hot Buffet Lunch ☐ (\$12)

Tuesday Afternoon, November 17

(1:30 p.m. to 5:00 p.m., including break)

- _____ Computers in Medicine: A Hands-on Workshop
- _____ Current Issues in the Management of the Menopausal Patient
- _____ Current Methods of Treating Breast and Prostate Cancer
- _____ How to Manage Psychiatric Patients
- _____ Family Violence - Focus on Spouse Abuse
- _____ Immunization Update - Convention and Controversy
- _____ Office Approach to Cardiac Arrhythmias
- _____ Rheumatologic Update 1992
- _____ What's New About Alzheimer's Disease

Wednesday Morning, November 18

(7:15 - 8:15 a.m., No Fee)

- _____ "Early Bird" Plenary Session on "Physician Assisted Suicide" (Continental Breakfast Included)

(8:30 a.m. to Noon, including break)

- _____ Basic Cardiac Life Support
- _____ Cardiovascular Risk Factor in the Diabetic Patient
- _____ Computers in Medicine: A Hands-on Workshop
- _____ Current Indication and Results of Total Hip and Total Knee Arthroplasty
- _____ Clinical Dermatology
- _____ Flexible Sigmoidoscopy: Indications and Technique
- _____ Family Violence - Focus on Elder Abuse
- _____ Physician Assisted Suicide: The Patient and the Physician Perspectives
- _____ State of the Art and Future Approaches to Brain Tumors

Wednesday Hot Buffet Lunch ☐ (\$12)

OR Women Physicians Luncheon ☐ (\$12)

Wednesday Afternoon, November 18

(1:30 p.m. to 5:00 p.m., including break)

- _____ Allergy/Asthma/Immunology Update - 1992
- _____ Benign Vascular Birthmarks, Psoriasis and Iohthysis
- _____ Colorectal Potpourri
- _____ Common Ophthalmic Problems
- _____ Current Issues Relative to Contraception
- _____ Hypercoagulability and Hemorrhage
- _____ Life and Death Issues of The Sandwich Generation
- _____ Pediatric and Adolescent Athletic Injuries
- _____ Radiology for Clinicians

Thursday Morning, November 19

(7:15 a.m. to 8:15 a.m., No Fee)

- _____ "Early Bird" Plenary Session on "Breast Cancer" (Continental Breakfast Included)

(8:30 a.m. to Noon, including break)

- _____ A Day in the Office with Your Cardiac Patients
- _____ Alternatives for Breast Reconstruction
- _____ Basic Cardiac Life Support
- _____ Current Approaches to the Management of the Obese Patient
- _____ Laparoscopic Surgery: Pros and Cons
- _____ Learning Disabilities in Children
- _____ Occupational Skin Disease
- _____ Sports Medicine: Primary Care Issues
- _____ The Clinical Approach to Diseases of the Esophagus

Thursday Hot Buffet Lunch ☐ (\$12)

Thursday Afternoon, November 19

(1:30 p.m. to 5:00 p.m., including break)

- _____ Clinical Applications of Positron Emission Tomography
- _____ Complications and Side Effects of Commonly Used Cardiovascular Drugs
- _____ Physical Activity and the Elderly
- _____ Prevention of Adult Diseases
- _____ Psychiatric Concepts: An Update
- _____ Selected Topics in Plastic Surgery
- _____ Treatment of the Injured Worker
- _____ Classic But Unusual Endocrine Diseases

Your Payment

MSMS Members: \$50 per course
MSMS Members with "retired status": \$25 per course
Residents: \$25 per course
Non-Members: \$75 per course
Students: Lunch Fee Only (\$12)

*NOTE: Each attendee must pay a \$15 one-time registration fee. Includes registration materials, handouts, refreshments, etc.

Send this entire page with your payment.
Confirmation of your reservation will be sent to you.

Multiply total number of half-day courses by appropriate fee:

_____ x \$50 (members) = \$ _____
_____ x \$25 (retired & residents) = \$ _____
_____ x \$75 (non-members) = \$ _____
_____ (free) Exhibit Hall Passes = FREE
Adopt-a-Doctor Discount* = \$ _____
One-time Registration Fee** = \$ 15.00
_____ x \$12 (lunch tickets) = \$ _____
Ann Jillian (Tuesday evening)
_____ x \$40 (w/dinner) = \$ _____
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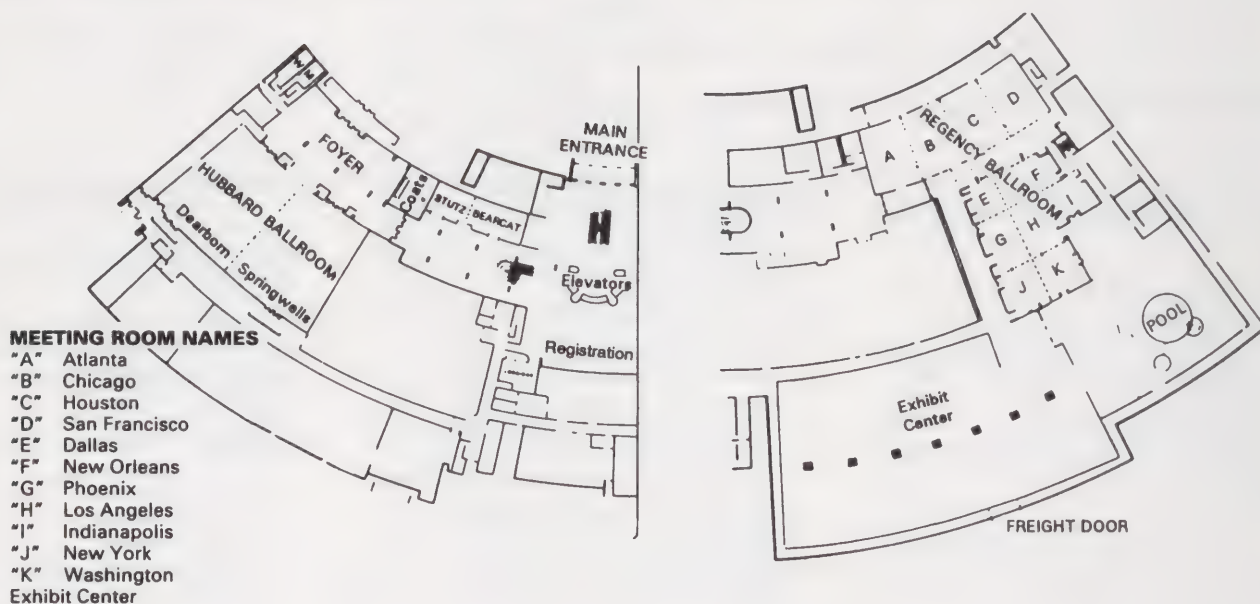
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The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 20 credit hours in Category I toward the requirements for Michigan relicensure and of the Physicians Recognition Award of the AMA, provided it is completed as designed.

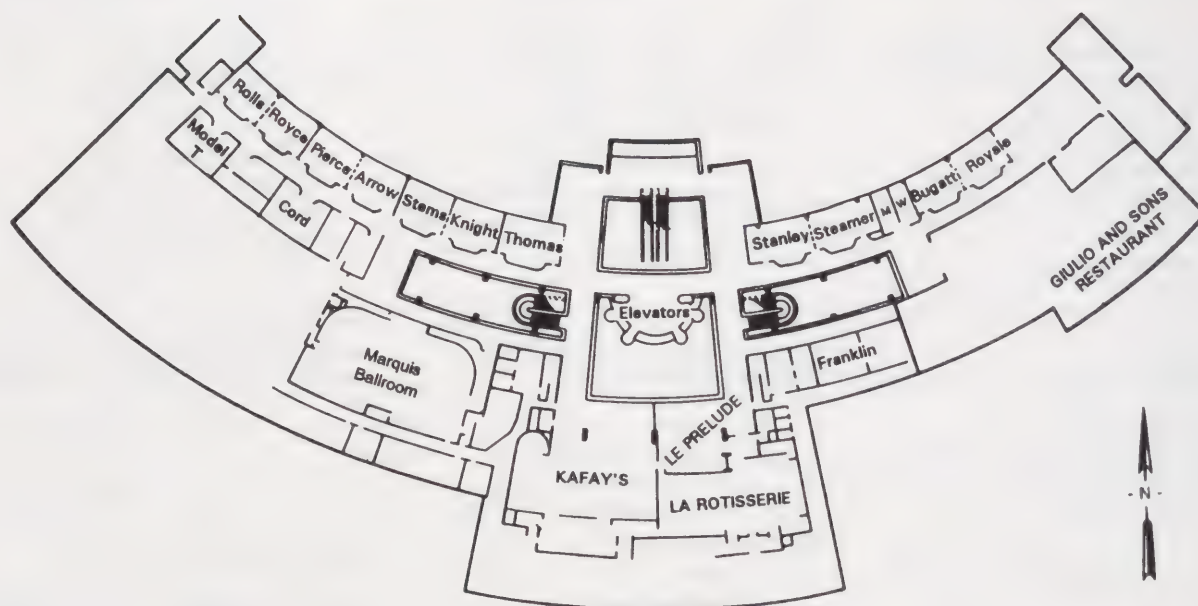
FLOOR PLANS

Atrium Concourse Level First Floor

1992 MSMS Annual Scientific Meeting November 17, 18 & 19 Hyatt Regency Dearborn



Conference Suite Level Second Floor



MSMS 1992 ANNUAL SCIENTIFIC MEETING TAPES AVAILABLE



The following Audio Cassette Tapes will be in the Exhibit Hall, Booth 103. EACH TAPE COSTS \$8.50 (Two tapes per course.)

- MSMS92-01** BASIC CARDIAC LIFE SUPPORT
- MSMS92-02** CLINICAL ISSUES IN AIDS/HIV MANAGEMENT
- MSMS92-03** GREAT LAKES WATER QUALITY: DEFINING THE HUMAN HEALTH THREAT
- MSMS92-04** IDENTIFICATION AND INTERVENTION IN FAMILY VIOLENCE- FOCUS ON CHILD ABUSE
- MSMS92-05** MULTI-DISCIPLINARY MANAGEMENT OF THE CHRONIC PAIN PATIENT
- MSMS92-06** PULMONARY FIBROSIS
- MSMS92-07** RECENT ADVANCES IN INFERTILITY THERAPY
- MSMS92-08** EMERGENCY ASSESSMENT AND MANAGEMENT OF ACUTE CARDIAC ISCHEMIA
- MSMS92-09** WIPING OUT SINUSITIS
- MSMS92-10** COMPUTERS IN MEDICINE: FROM DATABASE TO DIAGNOSIS, A HANDS-ON WORKSHOP
- MSMS92-11** CURRENT ISSUES IN THE MANAGEMENT OF THE MENOPAUSAL PATIENTS
- MSMS92-12** CURRENT METHODS OF TREATING BREAST CANCER
- MSMS92-13** HOW TO MANAGE PSYCHIATRIC PATIENTS IN A WORLD OF SHRINKING RESOURCES
- MSMS92-14** IDENTIFICATION AND INTERVENTION IN FAMILY VIOLENCE -FOCUS ON SPOUSE ABUSE
- MSMS92-15** IMMUNIZATION UPDATE - CONVENTION & CONTROVERSY
- MSMS92-16** OFFICE APPROACH TO CARDIAC ARRHYTHMIAS
- MSMS92-17** RHEUMATOLOGIC UPDATE 1992
- MSMS92-18** WHAT'S NEW ABOUT ALZHEIMER'S DISEASE
- MSMS92-19** BASIC CARDIAC LIFE SUPPORT
- MSMS92-20** CARDIOVASCULAR RISK FACTOR IN THE DIABETIC PATIENT
- MSMS92-21** COMPUTERS IN MEDICINE: FROM DATABASE TO DIAGNOSIS, A HANDS-ON WORKSHOP
- MSMS92-22** CURRENT INDICATIONS AND RESULTS OF TOTAL HIP AND TOTAL KNEE ARTHROPLASTY
- MSMS92-23** CLINICAL DERMATOLOGY
- MSMS92-24** FLEXIBLE SIGMOIDOSCOPY: INDICATIONS AND TECHNIQUE
- MSMS92-25** IDENTIFICATION AND INTERVENTION IN FAMILY VIOLENCE - FOCUS ON ELDER ABUSE
- MSMS92-26** PHYSICIAN ASSISTED SUICIDE: PATIENT AND PHYSICIAN PERSPECTIVES
- MSMS92-27** STATE OF THE ART AND FUTURE APPROACHES TO BRAIN TUMORS
- MSMS92-28** ALLERGY/ASTHMA/IMMUNOLOGY UPDATE - 1992
- MSMS92-29** BENIGN VASCULAR BIRTHMARKS, PSORIASIS AND IOHTHYISIS
- MSMS92-30** COLORECTAL POTPOURRI
- MSMS92-31** COMMON OPHTHALMIC PROBLEMS FACED BY THE PRACTICING PHYSICIAN
- MSMS92-32** CURRENT ISSUES RELATIVE TO CONTRACEPTION
- MSMS92-33** HYPERCOAGULABILITY AND HEMORRHAGE: COST EFFECTIVE LABORATORY DIAGNOSIS AND MANAGEMENT
- MSMS92-34** LIFE AND DEATH ISSUES OF THE SANDWICH GENERATION
- MSMS92-35** PEDIATRIC AND ADOLESCENT ATHLETIC INJURIES
- MSMS92-36** RADIOLOGY FOR CLINICIANS
- MSMS92-37** A DAY IN THE OFFICE WITH YOUR CARDIAC PATIENTS
- MSMS92-38** ALTERNATIVES FOR BREAST RECONSTRUCTION
- MSMS92-39** BASIC CARDIAC LIFE SUPPORT
- MSMS92-40** CURRENT APPROACHES TO THE MANAGEMENT OF THE OBESE PATIENT
- MSMS92-41** LAPAROSCOPIC SURGERY: PROS AND CONS
- MSMS92-42** LEARNING DISABILITIES IN CHILDREN
- MSMS92-43** OCCUPATIONAL SKIN DISEASE
- MSMS92-44** SPORTS MEDICINE: PRIMARY CARE ISSUES
- MSMS92-45** THE CLINICAL APPROACH TO DISEASES OF THE ESOPHAGUS
- MSMS92-46** CLINICAL APPLICATIONS OF POSITRON EMISSION TOMOGRAPHY (PET)
- MSMS92-47** COMPLICATIONS AND SIDE EFFECTS OF COMMONLY USED CARDIOVASCULAR DRUGS
- MSMS92-48** PHYSICAL ACTIVITY AND THE ELDERLY
- MSMS92-49** PREVENTION OF ADULT DISEASES
- MSMS92-50** PSYCHIATRIC CONCEPTS: AN UPDATE
- MSMS92-51** SELECTED TOPICS IN PLASTIC SURGERY
- MSMS92-52** TREATMENT OF THE INJURED WORKER
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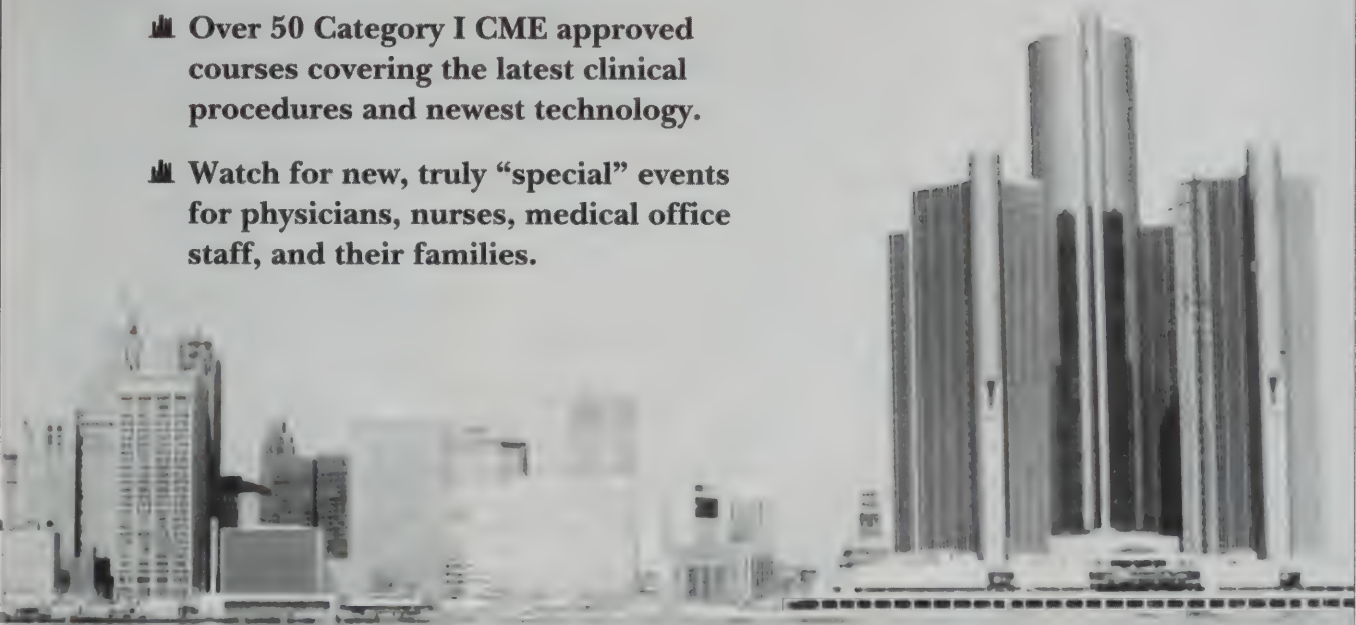
- MSMS92-54** ETHICAL ALTERNATIVES TO PHYSICIAN ASSISTED SUICIDE
- MSMS92-55** CONTROVERSIAL ISSUES IN THE MANAGEMENT OF BREAST CANCER

DETROIT

1993

**Michigan State Medical Society
Annual Scientific Meeting
November 9, 10, & 11, 1993
Westin Hotel, Detroit**

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MSMS Annual Scientific Meeting.*

MEETINGS

MSMS Meetings

October

20, 21 & 22, MSMS Practice Management Seminar, "Coding Institute", by Conomikes Associates, Inc., Hotel Barronette, Novi, MI. Contact: Office of Physician Education, (517) 336-5784.

27, 28, 29, MSMS Practice Management Seminar, "Medicare Update," by Conomikes Associates, Inc., October 27, WMU Regional Center, Grand Rapids, MI; October 28, Brookshire Inn, Williamston, MI, October 29, Hotel Barronette, Novi, MI. Contact: Office of Physician Education, (517) 336-5784.

November

3, 11, MSMS/MPMLC Risk Management "Closed Claim Review (Pediatrics)" Nov. 3, Novi Hilton, Novi MI; Nov. 11, Treasure Island, Saginaw, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

4, MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, MI.

Contact: William E. Madigan, MSMS Executive Director, (517) 337-1351.

5-6, MSMS Practice Management Seminar, "New Medical Biller Training Series-Blue Cross Blue Shield of Michigan," Pretzel Bell Restaurant, East Lansing, MI. Contact: Angela LaBonville, MSMS Department of Medical Economics, (517) 336-5723.

5, 6, MSMS/MPMLC Risk Management "Practice Parameters," Nov. 5, Novi, Hilton, Novi, MI; Nov. 6, Western Michigan University Regional Center, Grand Rapids, MI. Contact: Julie Smith, MSMS Chief, Risk Management (517) 337-1351.

16, MSMS AIDS Speakers' Bureau Update. Hyatt Regency, Dearborn, MI. Contact: Tracy Baker, MSMS Coordinator AIDS Provider Education Project, (517) 336-5770.

17, "A Conversation with Ann Jillian," Hyatt Regency, Dearborn, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

17-19, MSMS Annual Scientific Meet-

ing, Hyatt Regency, Dearborn, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 337-1351.

17, 18, 19, 20, MSMS/AMA Medical Office Staff Series, Hyatt Regency, Dearborn, MI. Contact: Office of Physician Education, (517) 336-5784.

December

3-4, MSMS Practice Management Seminar, "New Medical Biller Training Series-Medicare," Pretzel Bell Restaurant, East Lansing, MI. Contact: Angela LaBonville, MSMS Department of Medical Economics, (517) 336-5723.

7, 9, 10, MSMS/MPMLC Risk Management "The Legal Pitfalls Surrounding AIDS," December 7th, Park Place Hotel, Traverse City, MI; December 9th, East Lansing, MI; December 10th, Novi Hilton, Novi, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

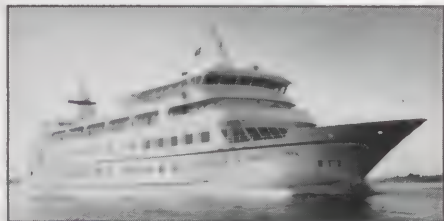
January

7-8, MSMS Practice Management Semi-

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MUNSON MEDICAL CENTER

MEETINGS

nar, "New Medical Biller Training Series-Medicaid," Pretzel Bell Restaurant, East Lansing, MI. Contact: Angela LaBonville, MSMS Department of Medical Economics, (517) 336-5723.

February

2-6, MSMS/MPMLC Risk Management Winter Conference, "Safeguarding Your Future," Keystone Resort, CO. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

4-5, MSMS Practice Management Seminar, "New Medical Biller Training Series-Commercial Carriers and Managed Care Programs," Pretzel Bell Restaurant, East Lansing, MI. Contact: Angela LaBonville, MSMS Department of Medical Economics, (517) 336-5723.

March

12-14, MSMS Joint Section Annual Meeting, Radisson on the Lake, Ypsilanti MI. Contact: Judy Marr, Manager, MSMS Department of Communications and Professional Relations, (517) 337-1351.

24-25, MSMS Maternal Health Care Conference, Holiday Inn South, Lansing, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

April

30-May 3, MSMS House of Delegates, Ritz Carlton, Dearborn, MI. Contact: Donna Farougi, Coordinator, Special Programs, (517) 336-5735.

July

14-18, MSMS Midsummer Board Meeting, Shanty Creek, Bellaire, MI. Bill Madigan, MSMS Executive Director, (517) 336-5734.

AMA Meetings

December

3-9, AMA Interim Meeting, Opryland Hotel, Nashville, TN. Contact: Judy Marr, MSMS Manager, Department of Communications and Professional Relations, (517) 337-1351.

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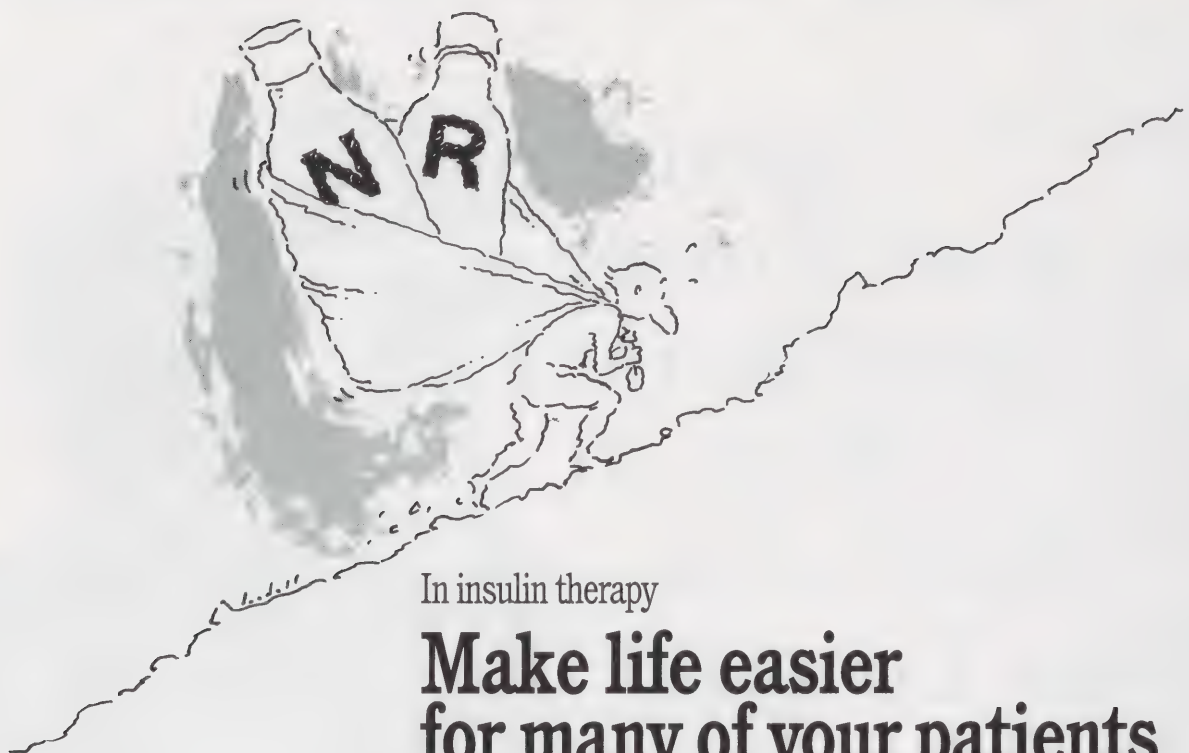


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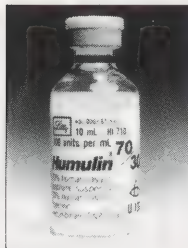
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

October

6, 13, 20, 27, Self Indulgence: A Conscious Resistance or Part of an Illness. **Location:** Bar-Levav Association, Southfield, Michigan. **Sponsors:** Bar-Levav Association. **Contact:** Joseph Gluski, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 8 hours Category I Credit.

21-23, A Symposium in Diabetes Care. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Michigan Diabetes Research and Training Center, American Diabetes Association. **Contact:** Robin Rice, Registrar, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI, 48106, (313) 936-1678. **Approved for:** 20 hours Category I Credit.

22, The Fourth Annual Modern Perinatal Problems. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Robin Rice, Registrar, Office of Continuing Medical Education, Towsley Center, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 15.5 hours Category I Credit.

22-24, Modern Perinatal Problems.

Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Robin Rice, Registrar, Office of Continuing Medical Education, Towsley Center, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 15.5 hours Category I Credit.

23, Bone & Soft Tissue Tumor Review Course. **Location:** William Beaumont Hospital, Royal Oak, Michigan. **Sponsor:** Zimmer-Berger Company of Michigan. **Contact:** Ronald B. Irwin, MD, (313) 644-3931. **Approved for:** 5 hours Category I Credit.

26-27, Child Abuse and Neglect. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Hospitals Child Protection Team, Michigan Committee for the Prevention of Child Abuse, University of Michigan Medical School. **Contact:** Robin Rice, Registrar, Office of Continuing Medical Education, Dept. of Postgraduate Medicine, University of Michigan Medical School P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 12 hours Category I Credit.

30, The Future of Mental Health Care - Moving In to the Community. **Location:** Wayne State University, McGregor Memorial Conference Center, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Psychiatry, Department of Psychology and Alliance for Mental Health Services. **Contact:** Claudia Gold, Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 661-2541. **Approved for:** 6 hours Category I Credit.

31, Brain Mapping/Clinical Neurophysiology of Sleep and Attention Disorders. **Location:** Northfield Hilton, Troy, Michigan. **Sponsor:** Beaumont Hospital. **Contact:** Peggy Hanson, RN, Beaumont Hospital Medical Bldg., 44199 Dequindre, Ste. 311, Troy, MI 48098, (313) 879-0707. **Approved for:** 5 hours Category I Credit.

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November

1-2, Fiberoptics Workshops for the Difficult Airway. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:**

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CATEGORY I COURSES

University of Michigan Medical School, Department of Anesthesiology. **Contact:** Robin Rice, Registrar Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI, 48106, (313) 763-1400. **Approved for:** 15 hours Category I Credit.

3, 10, Power in the Doctor-Patient Relationship: Defining its Ethical and Responsible Use. Location: Bar-Levav Association, Southfield, Michigan. **Sponsor:** Bar-Levav Association. **Contact:** Joseph Gluski, MD, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5300. **Approved for:** 4 hours Category I Credit.

4-7, Beyond Character Analysis: Focusing on the Healing Forces in Psychotherapy. Location: Bar-Levav Educational Association, Southfield, Michigan. **Sponsor:** Bar-Levav Educational Association. **Contact:** Helene Lockman, 3000 Town Center, Suite 1275, Southfield, MI 48075, (313) 353-5333. **Approved for:** 15.5 hours Category I Credit.

5-6, Selected Topics in Clinical Nutrition. Location: Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School and College of Pharmacy. **Contact:** Robin Rice, Registrar, Office of Continuing Medical Education, University of Michigan Medical School, Department of Postgraduate Medicine, Towsley Center, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 11 hours Category I Credit.

6-7, Endoscopic Sinus Surgery. Location: Gordon Scott Hall, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Otolaryngology. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 13 hours Category I Credit.

6-7, 10th Annual Detroit Trauma Symposium. Location: Harper Hospital Kresge Auditorium, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Harper Hospital, Detroit Receiving and University Health Center. **Contact:** Marjorie Norum, (313) 745-2345. **Approved for:** 8.5 hours Category I Credit.

CATEGORY I COURSES

8, Urban Medicine Symposium III.

Location: Hotel St. Regis, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Family Medicine, Michigan Health Center, and the Detroit Health Department. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 6 hours Category I Credit.

9-10, Epilepsy Advances: Psychological Problems in Epilepsy. Location:

Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Neurology. **Contact:** Robin Rice, Registrar, Towsley Center for Continuing Medical Education, University of Michigan Medical School, Department of Postgraduate Medicine, Towsley Center, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 16 hours Category I Credit.

12-13, Neonatology 1972-1992, Twenty Years of Problems, Progress, and Prospects. Location:

Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pediatrics. **Contact:** Robin Rice, Registrar, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 12.5 hours Category I Credit.

December

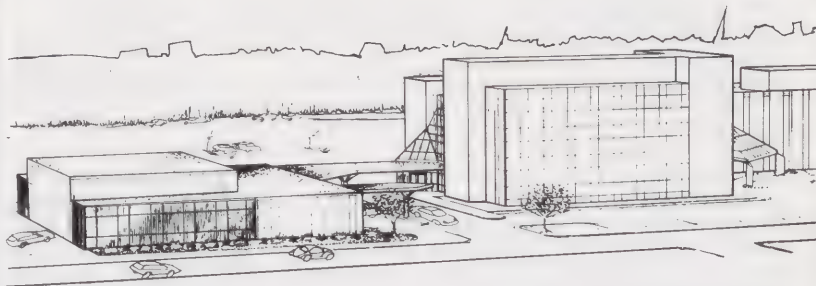
4-5, Women's Health Care for the Primary Care Provider. Location:

Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Family Practice, Department of Obstetrics and Gynecology. **Contact:** Robin Rice, Registrar Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 14.5 hours Category I Credit.

11-12, Psychiatry Update 1992: Medical Science for Psychiatrists. Location:

Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan

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CATEGORY I COURSES

gan Medical School. **Contact:** Robin Rice, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

13, Urban Medicine Symposium III.

Location: Hotel St. Regis, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Family Medicine, Michigan Health Center, and the Detroit Health Department. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 6 hours Category I Credit.

January

31-Feb. 5, The 17th Annual Midwinter Family Practice Update. Location:

Boyne Highlands Inn, Harbor Springs, Michigan. **Sponsor:** University of Michigan Medical School, Michigan Academy of Family Physicians. **Contact:** Robin Rice, Registrar Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 20 hours Category I Credit.

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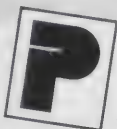
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Continued on page 83

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INDICATIONS AND USAGE

This drug product has been conditionally approved by the FDA for the prevention of angina pectoris due to coronary artery disease. Tolerance to the antianginal effects of nitrates (measured by exercise stress testing) has been shown to be a major factor limiting efficacy when transdermal nitrates are used continuously for longer than 12 hours each day. The development of tolerance can be altered (prevented or attenuated) by use of a noncontinuous (intermittent) dosing schedule with a nitrate-free interval of 10-12 hours.

Controlled clinical trial data suggest that the intermittent use of nitrates is associated with decreased exercise tolerance, in comparison to placebo, during the last part of the nitrate-free interval; the clinical relevance of this observation is unknown, but the possibility of increased frequency or severity of angina during the nitrate-free interval should be considered. Further investigations of the tolerance phenomenon and best regimen are ongoing. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS

Allergic reactions to organic nitrates are extremely rare, but they do occur. Nitroglycerin is contraindicated in patients who are allergic to it. Allergy to the adhesives used in nitroglycerin patches has also been reported, and it similarly constitutes a contraindication to the use of this product.

WARNINGS

The benefits of transdermal nitroglycerin in patients with acute myocardial infarction or congestive heart failure have not been established. If one elects to use nitroglycerin in these conditions, careful clinical or hemodynamic monitoring must be used to avoid the hazards of hypotension and tachycardia.

A cardioverter/defibrillator should not be discharged through a paddle electrode that overlies a Transderm-Nitro patch. The arcing that may be seen in this situation is harmless in itself, but it may be associated with local current concentration that can cause damage to the paddles and burns to the patient.

PRECAUTIONS

General

Severe hypotension, particularly with upright posture, may occur with even small doses of nitroglycerin. This drug should therefore be used with caution in patients who may be volume depleted or who, for whatever reason, are already hypotensive. Hypotension induced by nitroglycerin may be accompanied by paradoxical bradycardia and increased angina pectoris.

Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

As tolerance to other forms of nitroglycerin develops, the effect of sublingual nitroglycerin on exercise tolerance, although still observable, is somewhat blunted.

In industrial workers who have had long-term exposure to unknown (presumably high) doses of organic nitrates, tolerance clearly occurs. Chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitrates from these workers, demonstrating the existence of true physical dependence.

Several clinical trials in patients with angina pectoris have evaluated nitroglycerin regimens which incorporated a 10-12 hour nitrate-free interval. In some of these trials, an increase in the frequency of anginal attacks during the nitrate-free interval was observed in a small number of patients. In one trial, patients demonstrated decreased exercise tolerance at the end of the nitrate-free interval. Hemodynamic rebound has been observed only rarely; on the other hand, few studies were so designed that rebound, if it had occurred, would have been detected. The importance of these observations to the routine, clinical use of transdermal nitroglycerin is unknown.

Information for Patients

Daily headaches sometimes accompany treatment with nitroglycerin. In patients who get these headaches, the headaches may be a marker of the activity of the drug. Patients should resist the temptation to avoid headaches by altering the schedule of their treatment with nitroglycerin, since loss of headache may be associated with simultaneous loss of antianginal efficacy.

Treatment with nitroglycerin may be associated with lightheadedness on standing, especially just after rising from a recumbent or seated position. This effect may be more frequent in patients who have also consumed alcohol.



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After normal use, there is enough residual nitroglycerin in discarded patches that they are a potential hazard to children and pets.

A patient leaflet is supplied with the systems.

Drug Interactions

The vasodilating effects of nitroglycerin may be additive with those of other vasodilators. Alcohol, in particular, has been found to exhibit additive effects of this variety.

Marked symptomatic orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustments of either class of agents may be necessary.

Carcinogenesis, Mutagenesis, Impairment of Fertility

No long-term animal studies have examined the carcinogenic or mutagenic potential of nitroglycerin. Nitroglycerin's effect upon reproductive capacity is similarly unknown.

Pregnancy Category C

Animal reproduction studies have not been conducted with nitroglycerin. It is also not known whether nitroglycerin can cause fetal harm when administered to a pregnant woman or whether it can affect reproductive capacity. Nitroglycerin should be given to a pregnant woman only if clearly needed.

Nursing Mothers

It is not known whether nitroglycerin is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when nitroglycerin is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to nitroglycerin are generally dose-related, and almost all of these reactions are the result of nitroglycerin's activity as a vasodilator. Headache, which may be severe, is the most commonly reported side effect. Headache may be recurrent with each daily dose, especially at higher doses. Transient episodes of lightheadedness, occasionally related to blood pressure changes, may also occur. Hypotension occurs infrequently, but in some patients it may be severe enough to warrant discontinuation of therapy. Syncope, crescendo angina, and rebound hypertension have been reported but are uncommon.

Extremely rarely, ordinary doses of organic nitrates have caused methemoglobinemia in normal-seeming patients. Methemoglobinemia is so infrequent at these doses that further discussion of its diagnosis and treatment is deferred (see Overdosage).

Application-site irritation may occur but is rarely severe.

In two placebo-controlled trials of intermittent therapy with nitroglycerin patches at 0.2 to 0.8 mg/hr, the most frequent adverse reactions among 307 subjects were as follows:

	Placebo	Patch
Headache	18%	63%
Lightheadedness	4%	6%
Hypotension, and/or syncope	0%	4%
Increased angina	2%	2%

OVERDOSAGE

Hemodynamic Effects

The ill effects of nitroglycerin overdose are generally the result of nitroglycerin's capacity to induce vasodilatation, venous pooling, reduced cardiac output, and hypotension. These hemodynamic changes may have protean manifestations, including increased intracranial pressure, with any or all of persistent throbbing headache, confusion, and moderate fever; vertigo; palpitations; visual disturbances; nausea and vomiting (possibly with colic and even bloody diarrhea); syncope (especially in the upright posture); air hunger and dyspnea, later followed by reduced ventilatory effort; diaphoresis, with the skin either flushed or cold and clammy; heart block and bradycardia; paralysis; coma; seizures; and death.

Laboratory determinations of serum levels of nitroglycerin and its metabolites are not widely available, and such determinations have, in any event, no established role in the management of nitroglycerin overdose.

No data are available to suggest physiological maneuvers (e.g., maneuvers to change the pH of the urine) that might accelerate elimination of nitroglycerin and its active metabolites. Similarly, it is not known which, if any, of these substances can usefully be removed from the body by hemodialysis.

No specific antagonist to the vasodilator effects of nitroglycerin is known, and no intervention has been subject to controlled study as a therapy of nitroglycerin overdose. Because the hypotension associated with nitroglycerin overdose is the result of venodilation and arterial hypovolemia, prudent therapy in this situation should be directed toward an increase in central fluid volume. Passive elevation of the patient's legs may be sufficient, but intravenous infusion of normal saline or similar fluid may also be necessary.

The use of epinephrine or other arterial vasoconstrictors in this setting is likely to do more harm than good.

In patients with renal disease or congestive heart failure, therapy resulting in central volume expansion is not without hazard. Treatment of nitroglycerin overdose in these patients may be subtle and difficult, and invasive monitoring may be required.

Methemoglobinemia

Nitrate ions liberated during metabolism of nitroglycerin can oxidize hemoglobin into methemoglobin. Even in patients totally without cytochrome b₅ reductase activity, however, and even assuming that the nitrate moieties of nitroglycerin are quantitatively applied to oxidation of hemoglobin, about 1 mg/kg of nitroglycerin should be required before any of these patients manifests clinically significant ($\geq 10\%$) methemoglobinemia. In patients with normal reductase function, significant production of methemoglobin should require even larger doses of nitroglycerin. In one study in which 36 patients received 2-4 weeks of continuous nitroglycerin therapy at 3.1 to 4.4 mg/hr, the average methemoglobin level measured was 0.2%; this was comparable to that observed in parallel patients who received placebo.

Notwithstanding these observations, there are case reports of significant methemoglobinemia in association with moderate overdoses of organic nitrates. None of the affected patients had been thought to be unusually susceptible.

Methemoglobin levels are available from most clinical laboratories. The diagnosis should be suspected in patients who exhibit signs of impaired oxygen delivery despite adequate cardiac output and adequate arterial pO₂. Classically, methemoglobinemic blood is described as chocolate brown, without color change on exposure to air.

When methemoglobinemia is diagnosed, the treatment of choice is methylene blue, 1-2 mg/kg intravenously.

DOSAGE AND ADMINISTRATION

The suggested starting dose is between 0.2 mg/hr* and 0.4 mg/hr*. Doses between 0.4 mg/hr* and 0.8 mg/hr* have shown continued effectiveness for 10-12 hours daily for at least one month (the longest period studied) of intermittent administration. Although the minimum nitrate-free interval has not been defined, data show that a nitrate-free interval of 10-12 hours is sufficient (see INDICATIONS AND USAGE). Thus, an appropriate dosing schedule for nitroglycerin patches would include a daily patch-on period of 12-14 hours and a daily patch-off period of 10-12 hours.

Although some well-controlled clinical trials using exercise tolerance testing have shown maintenance of effectiveness when patches are worn continuously, the large majority of such controlled trials have shown the development of tolerance (i.e., complete loss of effect) within the first 24 hours after therapy was initiated. Dose adjustment, even to levels much higher than generally used, did not restore efficacy.

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References:

- Brady EM, Gold OG, Rosenbach HJ. Antianginal efficacy of transdermal nitroglycerin and oral nitrates: The ACTION Study. *Cardiovasc Rev Rep*. October 1988; 40-44.

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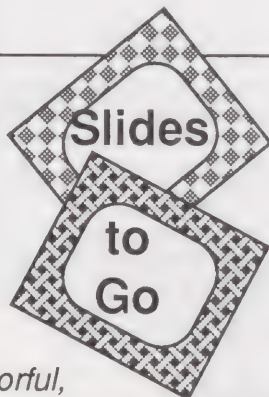
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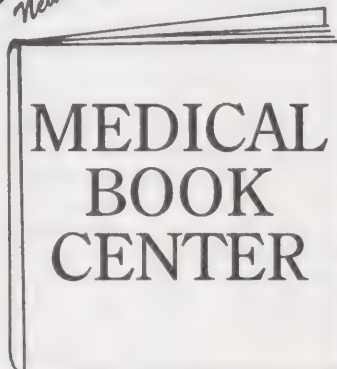
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President's Page

the Democratic caucus are controlled by the big-contributor trial lawyers who fear they will lose a substantial source of personal income if open season on physicians and hospitals is limited?

The Flint Journal editorially pointed out another truth.

"Both sides are to blame, especially the top leaders of both parties. It's time they stop playing these reckless games. It's time to stop putting party above citizens. It's time for the leaders to start acting like leaders. Let the people we elect to represent us do their jobs. Let them decide and resolve the issues before them."

Vote down non-supporters of liability reform

So what can we do about all of this? The most effective way to get the medical liability reform bill through the Michigan House -- re-

member, it already has passed the Senate and the Governor said he is eager to sign it -- is to defeat those candidates who do not support medical liability reform. We need only four or five new supporters in the House of Representatives to gain passage of an effective reform package.

What can you do? You can begin by looking closely into the House race where you are registered to vote. (While you're at it, make sure you are registered to vote.) Find out who your candidates are and call their campaign offices. Ask if they support medical liability reform.

If one of your candidates supports liability reform, make an offer to work for her or him. Offer to distribute campaign brochures to your friends and colleagues. Offer to send some money to help pay for brochures and advertising. Offer to host

a fundraiser in your home, or a neighborhood get-together. Offer to put a yardsign in your lawn. Offer to write a letter to your local newspaper publicly supporting him or her.

Little things work

These little things work. They make or break candidacies. Your influence as a physician in your local community is immense. Use it to accomplish what you know is right for your patients and for the profession. It can be a very rewarding experience.

If you don't feel you have the time or energy to get this involved, consider a contribution to MDPAC and we will work for you. Physicians from across the state put in a lot of time and effort interviewing candidates to find those most medicine-friendly, just as those opposed to us spend time finding and supporting doctor-bashers.

Sure, political action committees have taken a lot of verbal abuse, and in many cases, justifiably so. But they remain one of our few avenues of access outside of your direct involvement.

No doubt, inside politics is tough. It's nasty. And it's not pretty to watch. But consider the alternatives.

Do you think that couple in Nebraska would make the trip if they thought they might be ambushed on the way to the polls? Or if once they got there the voting machines were guarded by armed soldiers? Or once they were inside the booth there was only one party to vote for?

I still believe we get the government we deserve. If we throw up our hands in anguish over politics, the real anguish is only just beginning.

Get out and vote on Tuesday, November 3rd. ■

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Put on your hip boots and rubber gloves and wade right in -- Election time is near

Take the time to vote

By Thomas C. Payne, MD

A while back, Charles Kuralt's "Sunday Morning" program did a story on a young, Nebraska farm couple who had to use up an entire day traveling by two-track road to get to their polling place.

Often, they cancelled out each other's vote.

But the point was that they took their rights and responsibilities seriously and made the extra effort to cast their ballots. They were proud to be Americans.

Michigan residents this year are going to see more of the presidential candidates than nearly any other state. Political analysts see Michigan as a pivotal state for both George Bush and Bill Clinton.

I hope the national attention will put some enthusiasm back into the Michigan electorate, particularly physicians.

It scares me how often I hear colleagues complain about our "worthless," "ineffective," and "slimy politics as usual" political system. And it's not just physicians. Everyone seems to have a certain malaise and disenchantment with our political system. It's nationwide. Look at the joy Ross Perot initially instilled in many voters with his fresh talk of common sense.

Michigan voters, however, seem to be suffering from an even more advanced case of political pox. And with good reason. Currently, the state legislature is a morgue. Life juices are drained from important bills that come before it. The bills are locked into ice cold committees where they lie suspended until proper burial is arranged.

Little is moving in Lansing. Some say we're safer that way. Not I.

Partisanship is the cause of much of our frustrations with the legislature, but that should not be a surprise. Partisanship is really the dynamic that makes our two-party system function. Partisanship is an integral part of democracy. It's not pretty. It's not easy. It's not fun.

But as Winston Churchill said about democracy, it's the absolutely worst form of government on the face of the earth—except for all the others.

The only way to make democracy and its inherent partisanship work for you is to put on your hip boots and rubber gloves and wade right in.

Nothing else will work. Nothing else will get you what

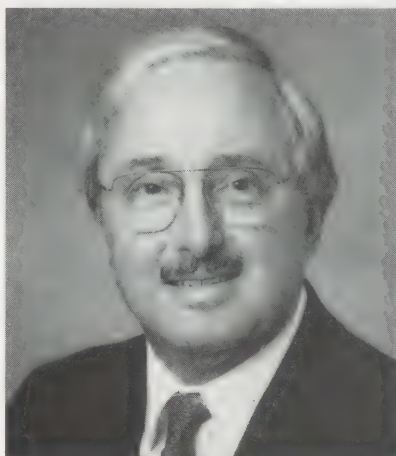
you want. Nothing else, particularly belly-aching, is worth your effort.

So you've got your waders on. What do you do now? Let's use our desire for medical liability reform as an example.

Abundant evidence points to the fact that the Democratic leadership in the Michigan House of Representatives does not want our medical liability package to pass. Even those Democrats who had co-sponsored the liability bill voted with Speaker Lewis Dodak for fear of ending up with an office the size of a broom closet and stripped of any powerful committee assignments.

Why is the Speaker so much against medical liability reform? Is it because certain members of

Continued on page 87



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NOVEMBER 1992
VOL. 91, NO. 11

*Award-Winning
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*Cover
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On the Campaign Trail
Frank B. Walker, MD

Value Enhancement The Real Challenge

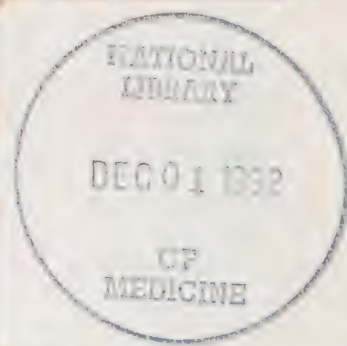
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MICHIGAN MEDICINE

NOVEMBER 1992 VOLUME 91, NO. 11

Award-Winning Journal of the Michigan State Medical Society

COVER STORY

There is strength in numbers. You've heard that phrase countless times before. But never has that phrase had more meaning for physicians than it does today. Physicians are in the midst of tremendous change, and the only way physicians can effectively deal with change is to meet it head on together -- as a unified force. This month's cover story beckons all physicians to join organized medicine and experience its power. Included are: A message from Dorothy Kahkonen, MD, chairman of the MSMS Committee on Membership Recruitment and Retention; an article by AMA Immediate Past President John J. Ring, MD, on why physicians must work together to put patients' needs first; an update on MSMS media relations; an explanation of the Michigan Physician's Communication Network; MSMS demographic information; and a look at Abbott Press, a new service for physicians.



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In next month's issue:

Medicine in the Year 2002

Cover illustration: By Robert L. Brent

Would you hire yourself as your money manager?



Jim MacDonald is an Investment Executive with PaineWebber in Troy, Michigan.

By Jim MacDonald

Until recently, gaining access to the most highly respected professional money managers to handle your investment portfolio required a lot of money--in most cases a minimum investment of \$1 million. But now you can gain access to the nation's leading money managers through a new kind of service offered by some financial service firms.

Who needs a money manager anyway? Professional athletes have help from the best personal trainers available to help them stay at the top of their form. Shouldn't that same type of professional help be available to investors who want to keep their portfolios in top shape?

Most affluent investors, small to mid-sized companies and other organizations lack the time and resources to manage their investment portfolios successfully. In fact, many of these investors would prefer to hand over the day-to-day investment decision making to a full-time professional manager. But, conducting the research to choose an

appropriate, quality manager from the more than 14,000 management firms listed with the Securities and Exchange Commission can be both time consuming and expensive.

Some investment executives at financial services firms can offer their clients access to these managers. Here's how it works. The investment executive acts as a consultant between investors and an elite group of top money managers. Usually, the managers will be pre-screened and carefully reviewed by the investment executive and his or her firm before becoming a part of the program.

A program like this should be more than just giving clients access to top rated money managers, however. It should be a comprehensive approach to total portfolio planning and ongoing management. The process must include three important steps: defining your investment objectives and risk parameters, choosing an appropriate money manager whose investment philosophy is consistent with yours and ongoing monitoring of the money manager's performance.

DEFINING INVESTMENT OBJECTIVES

For any long-term goal a well thought out game plan is required to achieve success. Your money management program should begin with a thorough understanding of your current financial status, liquidity needs, long and short-term goals and your tolerance for risk. This will help you get a picture of how all your assets -- cash, stocks, bonds, inheritance money, real estate holdings, retirement savings, etc. -- can work together so that you can achieve your financial goals.

CHOOSING A MANAGER

Whether your investment style is conservative, aggressive or some-

where in between, there's a money manager for you. You need not limit your choice of managers to only one manager; perhaps a combination of managers to handle different aspects of your portfolio would be the best approach for you.

PERFORMANCE MONITORING

Finally, one of your most important parts of your program should be continual monitoring of your money manager's performance to determine if your investment objectives are being met. Performance monitoring should include quarterly reports that give you and your investment executive an objective, statistical analysis of your money manager's performance. The report should list all your account holdings and compare your rate of return with appropriate market indexes as well as other professionally managed portfolios with similar investment objectives. And, because performance is based not only on return but also on the level of risk incurred to achieve that return, the report should also clearly access the volatility level of your portfolio during specific time periods.

Many of these types of programs are also convenient and cost effective. Look for one that features an annual "wrap" fee that includes the costs of determination of investment goals, money manager selection, professional portfolio management, quarterly performance monitoring, ongoing consultation with your investment executive, all commissions, custodianship of securities, automatic sweep of uninvested funds into a money market account and account insurance of up to \$10 million.

The key to successful portfolio management could be at your fingertips. Call your investment executive today, or call Jim MacDonald 1-800-446-0311 for further information about money management.



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MSMS Reimbursement Roundup



By Joyce Nurenberg
MSMS REIMBURSEMENT OMBUDSMAN

Reimbursement Roundup addresses third party payor reimbursement issues affecting physician practices. Comments and problems brought to the attention of the Reimbursement Ombudsman are routinely shared with the Liaison Committee with Blue Cross and Blue Shield of Michigan and its Subcommittee on Medicare Carrier Problems.

The Participation Decision

This month, you will receive your annual "Dear Doctor" letter and the opportunity to decide whether you will participate or decide not to participate with the Medicare program in 1993.

In 1992, the participation rate was 50.8 percent; in 1991, it was 50.5 percent. These numbers show that a significant number of physicians have chosen to remain non par despite HCFA's continuing efforts to change that. Each year physicians should review the new and old changes and their office practices to make an educated decision.

The latest incentive by the Health Care Financing Administration (HCFA) to encourage physicians to participate is to further limit the amount of money physicians can balance bill their patients. Effective January 1, 1993, the balance billing limit will be 115 percent of the non par fee schedule amount.

The limiting charge in 1992 could have been as low as 115 percent or as high as 120 percent. This is due to

the calculation Medicare employed using the physician's 1991 Maximum Allowable Actual Charge (MAAC) and subtracting the 1991 non participating prevailing screen. This difference was then divided by the non par prevailing screen to get a percent difference. The percent difference is then compared against the maximum 20 percent balance billing limit for 1992. If the percent difference was less than 20 percent, that figure was added to 100 percent to arrive at the 1992 limiting charge. If the percent difference was greater than 20 percent, 20 percent was added to 100 percent producing a maximum limiting charge of 120 percent.

It will be valuable for your office to do the math to see how much the flat 115 percent in 1993 will affect your office. The rate of 115 percent over the non par fee schedule amount is expected to continue in 1994 and beyond.

Financially, there is yet another decision to be made when a physician is non par and that is whether to accept assignment or not. Medicare reports that 91 to 93 percent of the 1992 claims submitted are sent assigned. In 1991, the figures ranged from 87 to 89 percent. These figures coupled with a 49 percent non participation rate suggest that many physicians are not collecting what they could be.

Continued on following page

REIMBURSEMENT ROUNDUP

Continued from page 5

The key to how successful your office will be is measured by your office staff's ability to collect the money from the patients at the time of the visit. Phone calls, mailing costs and associated staff time reduce the monetary difference over participation reimbursement.

Below are additional HCFA incentives that are not all new but that physicians should consider before making their decision this year:

■ When a claim is submitted *unassigned*, it is essentially impossible to get more than a verification from the Medicare Provider Inquiry department that the claim was "processed." Processed means completed rather than paid or rejected. Further information can only be obtained from the patient. A physician's office cannot even be

told the date the claim was processed.

(If a non par physician submits the claim assigned, office staff are entitled to the same information as par providers.)

■ Par provider claims are given priority in processing. Medicare has a standard of processing 95 percent of par claims within 17 days and non par claims regardless of whether submitted assigned or unassigned follow a standard 95 percent of claims within 24 days. Currently, there is a pilot program involving 50 physician offices that allows status claims by telephone. The criteria of selection for this program and for future participants will be that the office must be participating and must be an electronic filer.

■ HCFA is enforcing the balance billing limits. Letters have been

sent to providers notifying them of limiting charge violations and orders to refund patients. Next year it is expected that when a violation occurs, a notice will print on the patient's Explanation of Benefits Statement.

■ Currently on Explanation of Benefit Statements, the patient is informed of how much money the patient would have saved had he or she gone to a participating provider.

■ Non par physicians are required to provide written quotes on elective procedures that cost more than \$500. The quotes must include the amount Medicare will pay and how much the patient will be responsible for.

Although the deadline is December 31 to make your decision, it is best that physicians who change their participation status from the prior year do so as early as possible to allow time for Medicare staff to update the computer. Last year, physician offices were faced with additional administrative work because the Medicare computers were not updated until the second and third weeks in January, which resulted in incorrect payments being issued. Similarly, it is important to verify on your "Dear Doctor" letter your year of practice and area to be sure the proper fees have been sent. ■

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LETTERS

Doctor represents "very best of what our noble profession was meant to be"

I have written and lectured on the importance of a strong patient-doctor partnership as an adjunct in the healing process. I have been a physician for 25 years and during that time I have come in contact with many fine and dedicated doctors. I have also been involved in broadcast medical journalism for the last 11 years and have served as medical editor at Lifetime Medical Television and as host of the Michigan State Medical Society's WDIV-TV 5:30 pm News segment "4-Your-Health." In these capacities I have interacted with some of our country's best physicians.

On August 8, 1992, Jo Ann, my beloved wife of thirty-one years, died of lung cancer with brain metastases at the age of fifty-two. She fought courageously for twenty-eight months and during that time we were fortunate to come in contact with some very good doctors. This letter is to let you know of one who stood out and represents the very best of what our noble profession was meant to be.

Doctor Geoffrey Barger is a Neuro-Oncologist at the Detroit Medical Center. I knew he was something special the first time Jo Ann and I met him. He spent three hours with us that day, carefully going over every detail of her case and trying to get to know us. On many occasions he would come to our home and spend four hours at a time going over our options. He would always try his best to fit what was available into our particular needs. This was not cookbook medicine but just the opposite; a doctor reaching out and tailoring therapy to the needs of the patient and family. His caring and loving

manner sustained Jo Ann and our family and added immeasurably to the quality of her days.

The decisions we had to make were enormous and our choices were always limited and fraught with danger, but Doctor Barger struggled with us and he helped Jo Ann obtain as much quality and quantity of life as was possible to squeeze out of her extremely grave situation. Anytime, day or night, he would take time to speak with me. For this I will always be grateful.

One Sunday he invited Jo Ann and me to go for breakfast with him, his wife, Janet, and their two-year-old daughter Jenny, so that we could further discuss our options.

When the time came that we had run out of possibilities and death was imminent, Doctor Barger sat with our family at Harper Hospital one night and explained what we could expect. He cried with us and he hugged us. One of Jo Ann's closest friends was there that evening and was so moved by Doctor Barger that she too had to hug him. Whenever she calls me she says, "How's that wonderful Doctor Barger? Please say hello to him for me."

I once asked Doctor Barger if he listened to Dick Purtan's morning radio program on the way to work. He answered, "Stan, I used to listen to music in the car but I found that I needed the time to think about some of my patient's difficult problems and the music was interfering with my concentration. Now I drive with the radio off."

Doctor and Mrs. Barger now have a new baby son to go along with their beautiful daughter. He told me recently that he was trying to reduce his schedule from 110 hours a week to 80 hours so that he could spend more time with his family. My family and I are so fortunate that Doctor Barger was there

for us in our most difficult of times. His presence somehow eased the pain and helped soften the terrible tragedy that we all suffered.

I have always been exceptionally proud of the title "Doctor," but never so proud as when I am in the presence of Doctor Geoffrey Barger.

Stanley Alfred, MD
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A monthly update of key MSMS activities

MSMS committee will educate on assisted suicide alternatives

To help provide alternatives to anyone considering assisted suicide, the MSMS Committee on Bioethics is gearing up an education campaign on the issue for both the public and physicians. The committee plans to:

- help educate physicians on up-to-date methods of symptom and pain control when treating terminally or chronically ill patients;
- help physicians educate patients on distinctions between withdrawing and withholding treatment, assuring them their wishes will be followed in all decisions to use or forego medical treatment; and
- promote use of the durable power of attorney for health care forms that allow any adult to appoint a patient advocate to make treatment decisions for them if they become incapacitated.

The committee also plans to continue its forums on physician-assisted suicide, sharing conclusions with the MSMS Board.

MSMS to hold second joint section meeting

The 1993 MSMS Joint Section Meeting has been set for March 12-13 at the Radisson-On-The-Lake, Ypsilanti. The MSMS sections for Hospital Medical Staffs, International Medical Graduates and Young Physicians are planning the second of their joint meetings. The first was held this year. The sections will participate in a joint kickoff session, and then hold separate, but concurrent, meetings. Keynote speaker will be AMA Board of Trustees member Randolph Smoak, MD, South Carolina.

Annual Scientific Meeting has courses for all interests

Consider this topic--the pros and cons of laparoscopic surgery. How about a clinical approach to diseases of the esophagus? Both are areas physicians can learn more about at the 1992 MSMS Annual Scientific Meeting in Dearborn Nov. 17-19. But traditional scientific courses aren't the only bill of fare this year. Three half-day courses on aspects of family violence are on the agenda, along with a plenary session on physician-assisted suicide. Physicians also can learn about Great Lakes water quality, attend a hands-on workshop on computers in medicine, or choose from nearly four dozen other topics. Under the "adopt-a-doctor" discount, you can take one-third off your registration fee if you've never attended, or if you bring another physician who's never attended. Call the MSMS Office of Physician Education at (517) 336-5784 for details, or to register.

MSMS to mail practice survey to all members this month

Early in November, MSMS plans to mail a physician practice characteristics survey to all members. Questions will solicit data on medical practices, staffing and services, as better information is needed to aid work on the issues affecting Michigan physicians. All individual responses will be kept confidential. Watch for your survey in the coming weeks.

For details on these and other issues call William E. Madigan, Executive Director, MSMS, 517/337-1351.

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County Medical Societies **ON THE GO**

Michigan Medicine is pleased to feature this column which highlights the activities of county medical societies in Michigan. If the activities of your county medical society are not mentioned in this feature -- and you have some news you would like to share -- please contact Helen Fordham at MSMS.

Genesee County

The Genesee County Medical Society Foundation has received \$80,500 from the Community Fund of Greater Flint to fund the third year of the HIV Care Project.

Genesee County's Business Meeting was held on September 3 and featured a presentation entitled, "A Look Forward: The State and National Elections, Who Will Win and Who Will Lose?"

Ingham County

The Ingham County Medical Society has agreed to participate in the Lansing Business Health Policy Forum. The forum plans to bring together business, community and medical representatives to discuss health care issues and how they impact the community.

Physicians from Ingham County Medical Society have also agreed to join an Ingham County Board of Commissioners project that will focus on preventing unnecessary duplication of health care services in the Lansing area.

Wayne County

An internship program was held by WCMS on October 19 and 20. Five individuals representing *The Detroit Free Press*, Ford Motor Company, the Kellogg Foundation and the Detroit City Council got the opportunity to "walk in a physician's shoes" and share their concerns about health care. The mini-internship program



At its September 3 business meeting, The Genesee County Medical Society welcomed three speakers who discussed, "Look Forward: The State and National Elections, Who Will Win and Who Will Lose?" Featured speakers and guests (shown above) included (l to r): Paul Conn, of Conn and Associates; Thomas Shields, of Marketing Resource Group; Bill Ballenger, publisher of Inside Michigan Politics; and MSMS Assistant Director Kevin A. Kelly.

attempts to make non-physicians aware of the issues that affect physicians and how they practice medicine in Michigan.

Wayne County also hosted its first annual trade show September 30. Services available to physicians were exhibited at the medical society. Vendors included the WCMS telephone service, office supplies, financial services and insurance companies. Over 100 physicians attended the all-day event.

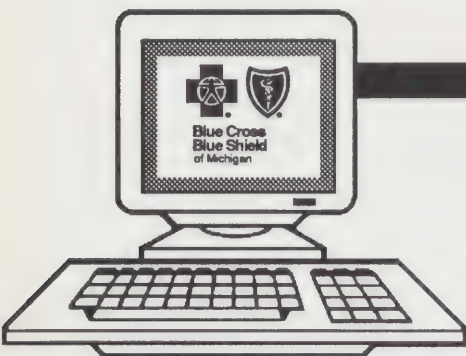
Oakland County

Oakland County's Public Information Committee has begun a program called Pro Bono Publico (for the good of the public) which endeavors to enlist physicians in pub-

lic service. Physicians are being sought to join the Alzheimers Speakers Bureau, make presentations to the American Lung Association seminars, and complete developmental assessments for the Catholic Social Services foster program.

Kent County

The Kent County Medical Society internship program was the focus of a local news story after a Channel 8 reporter completed the internship. The program, which was held September 20-22, included four interns and 13 physicians. Another is planned for January.



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New Michigan law redefines death

Death was once defined by law as the "irreversible cessation of spontaneous respiratory and circulatory functions." Advances in medical technology, however, coupled with a variety of other factors, have pointed to a need for a new statute defining death. (Other factors include concerns about physician liability, cases which argue death caused by removal of life support systems, and the inability to secure organ donations in a timely fashion.)

Under the new Public Act 90, death is defined as having occurred if there is an "irreversible cessation of circulatory and respiratory functions or there is irreversible cessation of all functions of the entire brain including the brain stem." Further, the law "requires a determination of death to be made in accordance with accepted medical standards and allows a hospital or other health facility or agency to designate which of its medical personnel may pronounce the death of a person in that facility."

The bill brings Michigan into alignment with 41 other states which have adopted the Uniform Determination of Death Act.

(Information from Public Sector Consultants, Inc.)

MDPH releases 1991 infant mortality statistics

Michigan's 1991 infant mortality rate declined slightly, according to figures released recently by the Michigan Department of Public Health (MDPH). Final statistics confirm that the statewide infant mortality rate declined from 10.7 in 1990 to 10.4 in 1991. The infant mortality rate is based on the number of in-

fantants who die in their first year of life per 1,000 live births.

There were 84 fewer infant deaths in 1991 (1,554) than in 1990 (1,638) as well as 2.4 percent fewer live births -- 149,478 versus 153,080. Additional findings show that the mortality rate for babies born to white mothers declined 5.1 percent from 7.9 in 1990 to 7.5 in 1991; whereas the 1991 mortality rate for babies born to black mothers remained virtually the same -- 21.7 versus 21.6 in 1990.

While pleased with the overall decline in the infant mortality rate, State Health Director Vernice Davis Anthony expressed disappointment that the black rate did not decline and is still more than double the white rate.

"The lingering gap between the black and white infant mortality rate is of great concern to all of us," said Anthony. "We were hoping that the most recent figures would show that some progress was being made in this area."

On a more positive note, Anthony added that the infant mortality rate declined 3.4 percent in the 13 Michigan counties targeted for special funding by the state health department. These counties (Berrien, Calhoun, Genesee, Ingham, Jackson, Kalamazoo, Kent, Macomb, Muskegon, Oakland, Saginaw, Washtenaw, and Wayne) were selected because they had the highest rate of both black and white infant deaths. The decline in these areas is attributed to several state and local coalitions and initiatives, including the Healthy Babies, Healthy Mothers Coalition; the Saginaw County Infant Mortality Coalition; the Wayne County Infant Health Promotion Coalition; and the "Baby Your Baby" public information campaign.

People 65 or older should get flu shot, U-M advises

Influenza vaccinations reduce the chances of people 65 and older being hospitalized for influenza or pneumonia by at least 45 percent, according to a study by researchers at The University of Michigan School of Public Health.

"And that is a conservative estimate. Other, smaller studies among different populations have found even greater effects," said David A. Foster, lead author and consulting researcher for the U-M Department of Epidemiology, and Arnold S. Monto, U-M professor of epidemiology.

"We urge all physicians to be aggressive about vaccinating their elderly patients," they added. Influenza is the sixth leading cause of all deaths in the United States.

The U-M study, which was based on data collected during the 1989-90 flu season, correlated hospitalizations for flu and pneumonia with information about vaccinations, or lack thereof, and health status of 1,907 people ages 65 and older.

"That was a particularly severe year when Type A flu, similar in strain to the 1987 A-Shanghai flu, was rampant and produced a high mortality rate," the researchers said.

The data was from two sources: information about the 721 hospitalized cases came from 20 acute care hospitals in southeastern Michigan while data on the 1,786 non-hospitalized individuals came from a random sample of Medicare recipients.

"We found that, after accounting for the effects of smoking, diabetes, asthma, anemia and heart, lung and renal diseases, those who had been vaccinated were 45 percent less

Continued on following page

Continued from page 13

likely to be hospitalized for influenza or pneumonia during the peak months of the season -- December to February," the researchers said.

The 1992-93 influenza viruses are expected to be the Beijing (type A H3N3), Texas (H1N1), and the Panama (type B).

Physicians asked to report influenza-like illness to local health authorities

Each year in Michigan, hundreds of people die as a result of the complications of influenza. Public health authorities need the help and cooperation of Michigan physicians in their efforts to promptly determine the type, geographic distribution and amount of influenza that is occurring.

Michigan local health departments will be coordinating epidemiologic surveillance of influenza for their areas of jurisdiction. Prompt reporting of increases in influenza-like illness to local health authorities is important because prophylaxis and treatment decisions depend on it.

A limited number of specimen collection kits are available for use in outbreak situations through local health departments. Testing of specimens for individual diagnostic purposes will not be available through the MDPH laboratory again this influenza season.

AMA issues report on induced termination of pregnancy; text available from MSMS

In recent years the national debate over abortion has intensified. In order to bring a clearer scientific perspective to this issue, the AMA Council on Scientific Affairs has prepared a report comparing rates of mortality and morbidity among women who terminated a pregnancy before the 1973 Supreme Court deci-

sion in *Roe v Wade* with rates among those who terminated a pregnancy after *Roe v Wade*. The major findings are as follows:

■ Abortion became much safer after 1973. The abortion-related death rate among women declined more than fivefold, from 3.3 deaths per 100,000 procedures in 1973 to 0.4 deaths per 100,000 in 1985. Increased physician education and skills in the procedure, improvements in medical technology, better access to safe and legal abortion services, and the earlier termination of pregnancy each helped reduce abortion-related mortality.

■ Deaths of women from abortion declined between the 1940s and 1972, both in absolute number and in the rate per million women aged 15 to 44. Most abortion deaths during this time were from illegal procedures. The introduction and use of antibiotics to manage sepsis accounts for much of the decline during the 1940s and 1950s. The widespread use of effective contraceptives, and an increase in the number of physicians who provided safe abortions contributed to the further decline in mortality during the 1960s.

■ The risk of dying from pregnancy and childbirth is nearly 12 times greater than the risk of dying from an induced abortion. In 1985, the maternal mortality ratio was 4.7 deaths per 100,000 live births, while the legal abortion mortality ratio was 0.4 deaths per 100,000 procedures. However, the risk of a woman dying from an induced abortion after the 21st week of gestation exceeds the risk of death from childbirth.

■ The risk of serious complications from a legal abortion is low, and most women who have a single abortion experience few if any problems getting pregnant or having healthy children in the future. Less is known about the effects of multiple

abortions on future fecundity. Adverse emotional reactions to abortion are rare; most women experience relief and reduced depression, distress and anxiety.

■ Abortion is safest for a woman when performed early in pregnancy and by a well-trained, experienced physician working in a setting equipped to handle complications that might arise. Mandatory waiting periods, mandatory consent and notification statutes, a reduction in the number and geographic availability of abortion providers, and a drop in the number of physicians who are trained and willing to perform first and second trimester abortions, increase the gestational age at which the induced pregnancy termination occurs, thereby also increasing the risk associated with the procedure.

■ Increasingly restrictive abortion laws in the United States will probably not result in mortality rates as high as those of 1940 to 1960. This is because some physicians who provide safe abortions will continue to do so, even under risk of prosecution, and because many women will travel to states with more moderate laws. Poor, adolescent, and minority women are most at risk for increased mortality and morbidity because they are likely to lose some of the access they currently have to improved and sophisticated medical technology.

For a copy of the report, contact Judy Marr at MSMS.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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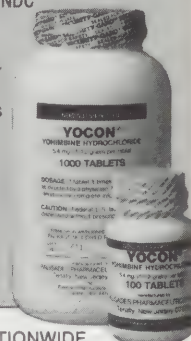
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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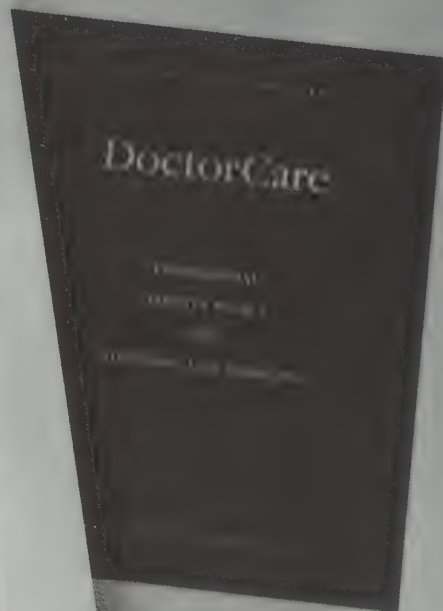
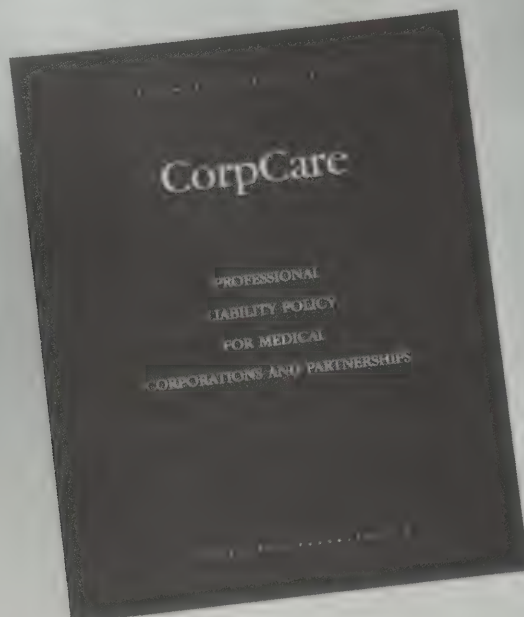
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PHYSICIANS IN THE NEWS



Robert A. Green, MD,
is the newly-elected president of the American Lung Association of Michigan. Doctor Green is a professor of internal medicine at the University of Michigan Medical School and staff physician at the Veteran's Administration Hospital in Ann Arbor.

Ananda Prasad, MD, PhD,
is a newly-elected lifetime member of the Wayne State University Academy of Scholars. A professor of medicine at the WSU School of Medicine, Doctor Prasad is a graduate of Patna Medical College, Birar, India. He received his PhD from the University of Minnesota in hematology and internal medicine. He is a member of numerous professional societies and has received many additional honors.

J. Brian Hancock, MD, FACEP,
is newly-elected president of the Michigan College of Emergency Physicians. Doctor Hancock is director of Emergency Medical Services for Saginaw County.

Charles C. Vincent, MD,
and his wife were recently honored by the Foster Grandparent Program of Wayne/Macomb County for their volunteer work within the community. Doctor Vincent is a member of the MSMS Board of Directors.

Cathy O. Blight, MD,
is a member of the College of American Pathologists Political Action Committee Board of Directors. A Flint pathologist, Doctor Blight is a member of the MSMS Board of Directors.

Rabbi Salimi, MD,
is newly-named Flint Satellite 1992 Physician of Year by the Crohn's and Colitis Foundation of America. This award was given in acknowledgement of Doctor Salimi's contri-

bution to the study and treatment of Crohn's disease and ulcerative colitis.

Robert N. Hensinger, MD,
is the newly-named president of the American Academy of Orthopedic Surgeons. He is professor of surgery and chief of the Division of Pediatric Orthopedics at the University of Michigan Medical Center.

Julian T. Hoff, MD,
is president-elect of the American Association of Neurological Surgeons. Doctor Hoff is professor of surgery and head of the Section of Neurosurgery in the Department of Surgery at the University of Michigan Medical Center.

William F. Chandler, MD,
is president of the Congress of Neurological Surgeons. Doctor Chandler is professor of surgery in the Section of Neurosurgery at the University of Michigan Medical Center.

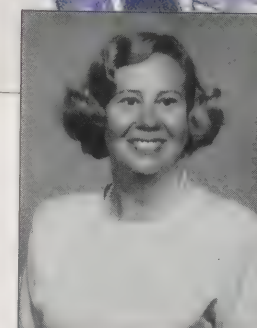
Karin M. Muraszko, MD,
is the Presidential Award Winner for the American Academy for Cerebral Palsy and Developmental Medicine for 1992. Doctor Muraszko is assistant professor of surgery and a pediatric neurosurgeon at the University of Michigan Medical Center.

Edward Wojtys, MD, and Laura Huston, MS,
are the recipients of the 1992 O'Donoghue Sports Injury Research Award for their paper, "Neuromuscular Performance in Normal and Anterior Cruciate Deficient Lower Extremities." Doctor Wojtys is an associate professor of surgery at the University of Michigan Medical Center. Huston is an orthopedic surgery research associate at the University of Michigan Medical Center.

William G. Zimmerman, MD,
is newly-named president-elect of the Flying Physicians Association. Doctor Zimmerman, of Grand Rapids, will become the president of the association in July, 1993.

Experience the Power of Organized Medicine

By Dorothy Kahkonen, MD



Doctor Kahkonen is chairman of the MSMS Committee on Membership Recruitment and Retention.

Medicine is changing! The mode of practice continues to evolve. And for many physicians, it is not what it was 10 or 15 years ago. However, along with change come challenges. The medical profession has never lacked for challenges, whether scientific or socioeconomic. One of the biggest challenges in the past year was the implementation of the Resource-Based Relative Value Scale (RBRVS) -- an enormous task indeed, one in which organized medicine rose to meet the challenge by providing the latest information and data available for members. MSMS and the AMA developed a pocket-size booklet for reference when learning to use the new CPT evaluation and management (E/M) coding system. MSMS provided 24 seminars for physicians and their staffs to further learn about the new system and the most accurate methods for their practice. MSMS continues to offer a Reimbursement Ombudsman to assist with billing problems or questions about the new codes.

This is but one example of what organized medicine has done for our members. Membership is vital to us. If membership declines so will our ability to have an impact in society at large. We must dedicate ourselves to an ongoing effort to contact nonmember colleagues and explain to them how important it is for them to join us in our struggle.

Many physicians are concerned whether they can continue to cope with the many changes that are developing in the healthcare environment -- an environment that directly affects their professional and personal lives.

Dealing effectively with representatives who create health care policy and with intermediaries who are responsible for implementation of new healthcare policy, is not a task that can be undertaken by physicians individually. Only in uniting our forces can medicine hope to achieve the recognition and clout necessary to help form positive public opinion and influence health care policy makers. We must continually strive for the development of fair and equitable health care services for all patients and physicians.

The policies and positions of MSMS are created through a democratic process that involves elected physicians from throughout the state. There could not be a fairer way to create and operate an organization. MSMS strength is only as great as those who join and participate. The more physicians it represents, the more representative it becomes. The role of organized medicine is clearly defined. To make it work successfully, greater member participation and support is now crucially necessary. Decide now to become a part of organized medicine. ►



Medical Professionalism: Put Patients First

By John J. Ring, MD



Doctor Baumann (top) is chairman of the Michigan Delegation to the AMA and serves as MSMS treasurer. Doctor Walker (above) is a member of the AMA Board of Trustees.



Physicians Must Work Together to Put Patients' Needs First

By Billy Ben Baumann, MD, and Frank B. Walker, MD

"Today, it is more difficult than ever before to put our patients' needs first, but it is more necessary than ever before because we have the technical know-how, but not the financial wherewithall, to deliver unlimited medical care. Our professionalism demands a commitment to the ethical imperative that financial considerations must never take precedence over our best medical judgment. Thus, the medical profession must take the lead in debate about what care is given and what is not. We must take the lead in developing local and national health care reform proposals that put patient welfare above all other concerns. And we must take the lead in assuring the public that its doctors are worthy of their trust."

These are the words of John J. Ring, MD, immediate past president of the American Medical Association -- words we strongly believe in. We recently asked Doctor Ring to prepare a few remarks for this month's issue of *Michigan Medicine*. Following is his article, which he titled, "Medical Professionalism: Put Patients First." We encourage you to read it and to answer his call for action.

When the public's experience of physicians as unquestionably ethical, competent and compassionate is undermined for any reason, that erosion threatens the unique trust that is essential for our profession to function at its highest level. So to re-assert our professionalism at this time when it is more important than ever before, the American Medical Association has undertaken an initiative to exhibit a strong, renewed, responsible sense of professionalism, both in our individual medical practices and also in our medical societies.

For instance, we have developed new and stricter policy on physician ownership and self-referral. Though under some circumstances, physician investment can benefit patient care, it also creates the potential for conflict of interest. In general, our position is that physicians should not refer patients to a health care facility at which they do not directly provide care or services when

they have a monetary interest in the facility. We advise that self-referral may only take place where physicians can show a clear medical need and where they can show there are no adequate alternative facilities or alternative financing.

Our Council on Ethical and Judicial Affairs said this policy has "important symbolic significance" because of what it tells the public and policymakers about how seriously we physicians take our profession's "unique ethical tradition."

The same is true of our policy on gifts from industry to physicians, which the Pharmaceutical Manufacturers Association has endorsed. We advise that gifts "should primarily entail a benefit to patients and should not be of substantial value." Cash or travel, lodging and personal expense subsidies are not acceptable, nor are gifts that are tied to a physician's prescribing practices. Money for continuing medical education should go to conference sponsors -- not individuals -- to reduce registration fees.

Policing our profession

Since the mid-seventies, Justice Department and Federal Trade Commission lawsuits and antitrust actions began giving medicine a clear message that self-regulation can be dangerous to a physician's career and began forcing onto physicians the model of free-market competition at the expense of medical professionalism. Yet Congress and HCFA often belie the free-market approach, as indicated by the fact that last year alone the federal government imposed seven new regulatory plans on physicians.

We in the American Medical Association are determined to find positive, definite, innovative ideas to back up the AMA ethical principle that: "A physician shall strive to expose those physicians deficient in character or competence or who engage in fraud or deception." Last year, we began denying membership to the most obvious violators of our ethical code: those physicians whose licenses have received adverse actions from their state medical boards. We have been discussing with the Federation of State Medical Boards ways to work with state boards to improve peer review. And our AMA has also called for PRO changes to assure peer review is "based on concern for quality of care with an emphasis on education rather than financial considerations."

Building on our well-established process for identifying and rehabilitating impaired physicians, we have published the Guidebook for Medical Society Grievance Committees and Disciplinary Committees. It

comes with a promise that our AMA will provide legal defense for any society that is sued by a physician in its disciplines.

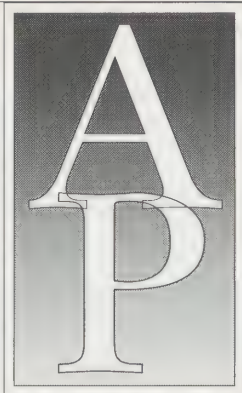
Finally, we have requested the Federal Trade Commission to change legal restrictions so the profession can monitor itself more effectively. We are petitioning the FTC to establish a model community-based physician committee to mediate patient fee complaints and discipline fee gouging, as most local committees once did. Under this new proposal, medical society members would be required to participate in the mediation process or lose their memberships.

Clearly, we need to build more effective mechanisms to identify, rehabilitate and -- if need be -- take corrective action concerning those among us who do not represent our profession well because they are impaired, incompetent, or unethical. And just as clearly, the principles of good peer review demand the medical profession be involved. As for the charge that this gives the fox the job of guarding the chicken coop, nothing could be further from the truth, as anyone who understands what professionalism is can appreciate.

In the March 1992 issue of *The Atlantic*, Arnold Relman, MD, editor emeritus of *The New England Journal of Medicine*, wrote about "de-professionalization" and a decline of ethics in medicine in an article titled, "What Market Values Are Doing to Medicine." In this piece, Doctor Relman maintains that for a long time, the tradition of medical professionalism was powerful enough to ward off any thought that medical care is a commodity rather than a social good. But he states that in the past two decades, "Health care has become commercialized as never before and professionalism in medicine seems to be giving way to entrepreneurialism."

I, too, have long worried about the decline of professionalism and the rise of commercialization. In my inaugural address last year, I asked my colleagues, "Are we a profession to which business interest is incidental? Or are we a business to which our professionalism is incidental?" There can be only one answer. Medicine is a profession. Physicians are professionals. We put our patients' interests above our own. ■

Doctor Ring is immediate past president of the American Medical Society.



A New Service for Physicians

Abbott Press

marks first year as physician's printer

By Claudia Skutar

Abbott Press has a lot of energy for a youngster. In fact, in the year since its creation by MSMS, the in-house press has grown to full adulthood, rivaling many Michigan printers in its output.

What's that got to do with physicians? Well, for one thing, doctors, like any other business owners, need business cards, stationery and forms for their practices. Abbott Press can provide all that at competitive prices. And, unlike other printers, Abbott Press was started with physicians in mind.

"We viewed this as another service MSMS can provide its members," said MSMS Board of Directors Chairman Jack L. Barry, MD, Saginaw.

MSMS Board Treasurer Billy Ben Baumann, MD, Pontiac, observed that the "whole rationale for getting Abbott Press started was to provide member services while keeping the pressure off dues increases."

Part of the MSMS long-range strategy, explained Doctor Baumann, is to participate in businesses that make money to help pay for services to members.

Profits from Abbott Press and other MSMS subsidiaries help MSMS strengthen current services and create new ones without asking members for more money through annual dues increases.

When analyzing outside income sources, the Board saw that the creation of Abbott Press was a natural solution to expanding services without increasing costs.

"We examined projected expenses and revenue, and the venture looked good," said MSMS Committee on Ways and Means Chairman Robert C. Prophater, MD, Bay City. "We felt that the business would become a money-making venture in less than two years."

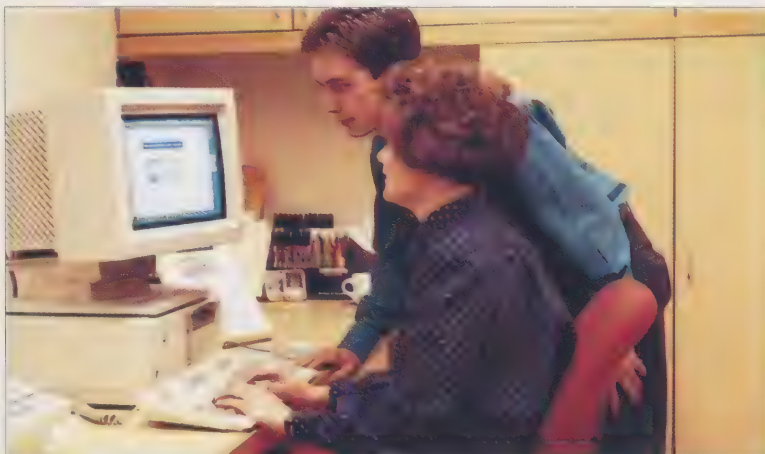
Not only did MSMS "have a nucleus for business" among its own member ranks, but the association itself was buying a tremendous amount of printing simply to carry out business and communicate with members, noted Doctor Baumann.

"Communication is so important that it's one of the largest components in the MSMS budget," Doctor Barry pointed out. "It made sense to the Board to consider a printing venture, not only to help physicians directly, but to dramatically cut MSMS communication costs by printing in-house."

MSMS reviewed similar operations at other associations to observe equipment and staff, and to glean ideas. One operation reviewed was the in-house press of the Texas Medical Association, which has been, as

Bill Yauch (far left), Ryan Dickerson (center left), Gary Vallance, chief of Abbott Press printing operations (center right), and Dave Isbell (far right) operate printing equipment which runs two full-time shifts to produce newsletters, stationery, envelopes, business cards and many other printed pieces for physicians, MSMS and other organizations.





Using desktop publishing software, graphic designers Steve Amor and Barb Borucki design one of the many pieces printed by Abbott Press each month.

Doctor Baumann noted, "fabulously successful."

Following an 18-month planning process, the Board gave the go-ahead to start on physical development of the printing company. Designs by an outside consultant were used to restructure two rooms on the basement level of MSMS East Lansing headquarters into one. Both a printer and graphic artist were hired, and printing equipment was purchased and set in place.

One of the first jobs Abbott Press tackled in November 1991 was printing the weekly MSMS newsletter *Medigram*. No small assignment, an average of 11,000 copies of this four to eight-page piece are printed weekly and sent to all MSMS members.

Abbott Press quickly moved on to producing brochures, fliers, ads and newsletters for physicians and for MSMS. The company also expanded into printing for affiliated organizations. For instance, Abbott Press designs and prints the monthly newsletter for the Michigan State Medical Society Auxiliary.

A natural choice for physicians

"Our ties with other organizations such as the Auxiliary and county medical societies make Abbott Press a natural choice for handling their printing needs," said Doctor Barry. "Who better to help than a press that specializes in printing for the medical profession?"

Abbott Press has grown quickly in its first year. Doctor Baumann said the Board is pleased with what it's seen so far. The printing company can handle all sides of the process from initial design to a final printed piece.

One service the company is eager to tell doctors about is its ability to offer complete business packages that include business cards, new physician announce-

ment cards, letterhead, envelopes, office forms, notepads, invitations, and notice of relocation postcards and ads. Through Abbott Press, busy physicians now can turn to a printing company that specializes in printing for the medical profession at costs targeted below local market prices.

Indeed, many physicians already are availing themselves of the service. During a single month this year, Abbott Press printed more than 200,000 envelopes, 400,000 sheets of letterhead, and 10,000 business cards.

The volume of overall business has grown so large so quickly that the printing company added a full-time evening shift and second graphic artist last summer. The two graphic artists now are completing 75 projects a month.

In addition to that, one graphic artist spends time each month typesetting and laying out copy for *Michigan Medicine*.

It's been a good first year for the printing company. If you walk through the lower level of MSMS headquarters, the presses can be heard from early morning until late evening, long after the cleaning crew has shut off the lights in the rest of the building and gone home.

With two sales representatives on staff to get out and talk with physicians, even more business is expected in the coming year.

Doctor Barry summed up Abbott Press in this way:

"In today's economy, people, including physicians, are looking for value. There is great value in someone who understands your business, and can help with your specific needs. That's what Abbott Press is all about."

For more information about Abbott Press services, call Laurie Hope at (517) 336-5760.

Claudia Skutar is communications specialist for MSMS.

“Through Abbott Press, busy physicians now can turn to a printing company that specializes in printing for the medical profession at costs targeted below local market prices.”



MSMS Media Relations.

Good News for Michigan Physicians

By David K. Fox

"Media relations is like driving in the fog with your headlights on. It's not that *you* see any better, but it allows *other people* to see *you* better.

Media relations is something like the emergency room. You prepare for the worst and wait.

Lately, however, there hasn't been much waiting.

MSMS has seen a dramatic increase in calls from newspaper, radio and television reporters eager for organized medicine's comments on breaking health care stories. In the past five years, as health care and medicine have become daily front page news, the number of calls has increased from just three or four per week to more than half a dozen a day. We had a recent record high of 30-plus calls when Doctor Kevorkian came to visit the Board of Directors September 16. The number of news releases, editorial board visits and news conferences designed to promote medicine's side of health care issues also has increased substantially over the years.

Most media requests for interviews are handled by the president of MSMS. Other officers including chairman, vice chairman, president elect and immediate past president also are called on. Committee chairmen and committee members with expertise on specific topics such as legislation, reimbursement, AIDS and bioethics also are frequently asked to explain complex issues in lay terms for clear understanding by the general public.

County society presidents, specialty society presidents and many other individual physicians throughout the state also are asked

by MSMS to do media interviews if the news person want to "localize" their story.

To help local physicians prepare for media interviews, MSMS has developed the Physician Communication Network (PCN). (See next page for details.)

Topics of recent media calls include many dozens on assisted suicide, several on medical liability reform, and a few on the AAA ballot proposal.

While many calls from the media are fairly routine, we do get an extremely wide variety of requests. (See sidebar.)

Even though many questions asked by the media are often difficult and frequently time-consuming, the real value is in building credibility with the media over an extended period of time. That credibility is important when we attempt to get our side of the story out on issues.

We also try hard to show the public that physicians are working to improve health care in Michigan through media coverage of the Annual Scientific Meeting, the Maternal and Perinatal Health Conference, and public health resolutions at the annual MSMS House of Delegates meeting.

As an expert in the field once observed, "media relations is like driving in fog with your headlights on. It's not that *you* see any better, but it allows *other people* to see *you* better."

Dave Fox is chief of media relations for MSMS.

Inquiries address variety of topics

MSMS receives hundreds of calls from the media regarding a variety of health care topics. Following is a sampling of the questions received in the past few months:

- "Is prayer an important adjunct to medical care?"
- "What is your position on the 'designer' drug laws?"
- "What is your position on the bill to expand the scope of practice of optometrists?"
- "What about physicians referring patients to labs they own?"
- "What is the number of Caesarean births in Michigan? Is the rate up or down?"
- "What is the definition of brain death? Do you support legislation to clarify when death occurs?"
- "Should patients get a second opinion if they want one and how do they go about it?"
- "Do you support legislation to create a Health Professionals Clearinghouse?"
- "Should organs be harvested from the Florida baby who was born without a brain?"
- "Do physician offices comply with the state's mammography guidelines?"
- "Who can I talk to about the nicotine patch?"
- "Is the procedure done at vein clinics an appropriate procedure?"
- "Are primary care physicians reluctant to treat HIV-infected patients?"
- "What is your position on abortion?"
- "What are the medical aspects of the homeless?"
- "Is it proper for physicians to advertise?"
- "What is the medical society's position on health care reform?"



The Michigan Physician's Communication Network (PCN)

A one-of-a-kind program for MSMS members

By Helen Fordham

Grassroots activism is the buzz word of the '90s. At the Michigan State Medical Society, the Physician's Communication Network (PCN) is tapping into the power of grassroots members.

"The PCN is part of a strategy to involve all members in public relations and advocacy programs," explains MSMS President Thomas C. Payne, MD. "We had so much success with the Physician Legislative Network program that we decided to apply the same principle to communications."

The concept of the PCN grew out of a vision of unified member involvement in issues that affect the public's welfare.

"There was a sense that if physicians were motivated on a local level to express their views this would go a long way in helping to educate the public and inform the legislature," explains W. Archibald Piper, MD, chairman of the MSMS Committee on Communications and Professional Relations.

Balanced against this grassroots strategy was a growing demand from physicians across the state for MSMS to keep them informed of the important issues confronting medicine. Physicians wanted to know what MSMS was doing, explains Doctor Piper, and how physicians could help in presenting "their side of the story" to the public.

MSMS set about meeting this dual demand by developing the PCN. A two-step process was established for initiating members into the program. First, physicians iden-

tified as potential spokespeople or leaders in medicine, are selected to participate in media training workshops. These workshops are run by a public relations consultant who familiarizes the physicians with how the media functions. In four-hour sessions a range of topics are covered including public speaking, how to be proactive with the local press, how to write letters to the editor, how to deflect aggressive or loaded questions and how to put your point across. In addition, the sessions include a mock interview which helps make physicians more comfortable with cameras and bright lights.

Eleven workshops have been held over the last two years at locations ranging from Detroit to Marquette. Approximately 200 physicians have been trained to deal with the press.

"Feedback from these workshops has been very positive," says Doctor Piper. Ken Rowe, MD, one of the attendees at the Marquette workshop found the training valuable. "I hope to use the excellent advice if called upon to represent MSMS," he says.

Training worthwhile

Most physicians have found the experience very worthwhile -- so worthwhile, in fact, that there have been repeated requests for longer sessions. The original intent of the workshops was to give physicians basic training, explains Doctor Piper. However, staff have discovered that many of the physicians have had some degree of exposure

to the press, necessitating more advanced workshops. MSMS is currently planning to develop advanced workshops which should be in place by 1993.

After the physicians have been trained to deal with the media they are invited to join the PCN. These members receive regular mailings keeping them updated on events and campaigns that are occurring in medicine and are called upon to assist in publicizing a variety of MSMS and AMA programs. "We are not training physicians to make them mouthpieces for MSMS activities," says Doctor Piper, "but rather to let them know what is going on at the state level so they can respond in an informed manner to local inquiries."

Physician assistance often takes the form of letters to the editor. Network members' names are also included in county speakers bureaus and state and local media contact lists.

MSMS has run two major campaigns this year which have drawn on the PCN for assistance in publicizing and educating the public -- the first was on medical liability reform and the second was in support of anti-smoking legislation.

"The PCN is the only program of its kind in the nation," explains Doctor Piper, "and MSMS has found it very effective in informing local communities throughout the state about health issues." ■

Helen Fordham is chief of community relations for MSMS and serves as staff coordinator for the PCN.

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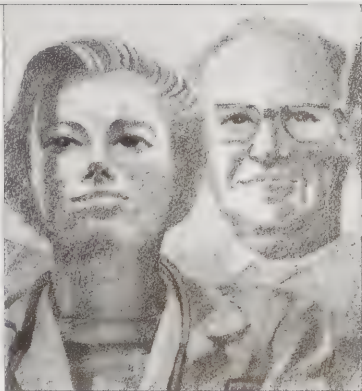
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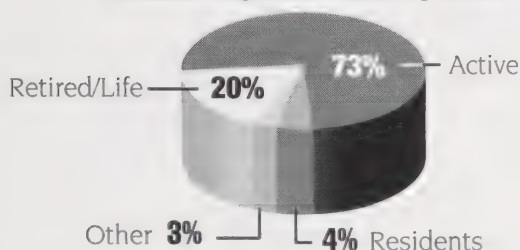
Demographic Information

The following data represent a picture of current MSMS membership. The charts and graphs include information regarding the following:

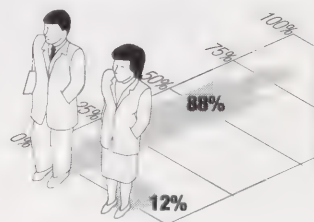
- Membership by gender
- Membership distribution by class
- Membership distribution by title
- International medical graduates

The Department of Membership Recruitment and Retention presents this data for your information. If you have any questions regarding this information, contact Deborah Zannoth at MSMS.

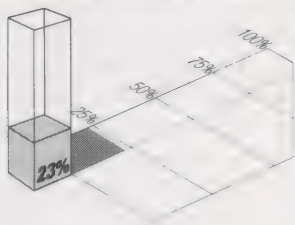
Membership Distribution by Class



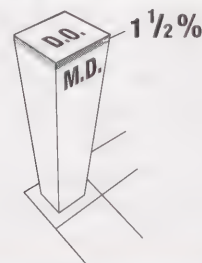
Membership by Gender



International Medical Graduates



Membership Distribution by Title



Watch for a complete guide to MSMS member services in the January issue!

MSMS offers a plethora of programs, services and activities for its physician members. Spouses, too! The January 1993 issue of *Michigan Medicine* will include a complete guide to member services, MSMS staff and officers, and more. In addition, the January issue will serve as the 1993 MSMS Membership Directory.

Look to this special issue for information on:

- MSMS sections for international medical graduates, young physicians, hospital medical staff, and medical students.
- MSMS Auxiliary.
- MSMS committees and task forces.
- Brochures and other informational items.
- A guide to county medical societies and staff contacts.
- Whom to Call at MSMS.
- Much more!



FRANK B. WALKER, MD

A national leader for physicians

By Helen Fordham

He is a rock. Big of build, honest of manner and a straight talker, Frank B. Walker, MD, doesn't dissemble. You know exactly where you stand with this man.

Described by colleagues as reliable and trustworthy, Doctor Walker values integrity and hard work. These are the traits he brings to the AMA Board of Trustees, traits he hopes will help him get re-elected in the June 1993 elections.

"In the unknown and perilous times ahead for medicine, the AMA is the only national organization that can influence the course of health care in a global fashion," says Doctor Walker. "I want to be a part of that."

Four positions are available on the AMA Board of Trustees. Already, there are eight declared candidates including three incumbents, and Doctor Walker is campaigning hard.

In the last campaign, candidates sent out slick promotions and glossy brochures. Doctor Walker opted for a more personal touch and hand wrote individualized letters to the 800 AMA delegates.

Commitment, desire strong

The message Doctor Walker is sending out this year is clear -- he wants a three-year term on the AMA Board of Trustees. "The AMA plays a crucial role in lobbying for physicians and they are the best organized and most logical choice to speak for American medicine, he says, "I want to be a part of this exciting process."

"The AMA has supported me in the past and has given me the opportunity to contribute. They have invested in me and I owe it to them to justify their confidence."

Doctor Walker sees his many years of experience with the AMA as

a valuable asset and proof of his commitment.

No stranger to campaigning, Doctor Walker has racked up some impressive accomplishments in his 37 years as a physician. He has served as chairman of the MSMS Board of Directors, past president of the Wayne County Medical Society, and president of the American Society of Clinical Pathologists.

Ever hungry for new challenges, it wasn't long before Doctor Walker moved on to the AMA where he served as vice chairman and chairman of the Michigan Delegation from 1980 to 1988. In addition, he was a member and chairman of the AMA Council on Long Range Planning and Development. He served as chairman of the AMA Finance Committee in 1990 and is current chairman of the AMA Board Audit Committee, representative of the AMA Board of Directors to the Commis-

sion on Office Laboratory Accreditation and chairman of the AMA Commissioners to the Joint Commission on the Accreditation of Health Care Organizations.

Unbelievably, Doctor Walker balances these commitments with his work as director of laboratory services at three Detroit area hospitals. Yet he is eager for more.

As fourth in a fifth generation dynasty of physicians, Doctor Walker was weaned on medicine. A Walker was on the original faculty of the Detroit College of Medicine in 1868. Doctor Walker's grand-uncle, grandfather, father and brother were all in medicine and his son and daughter-in-law are set to follow suit as OB-GYN residents at Hutzel Hospital, Detroit.

Immersed in medicine from birth, there was never any conscious decision to become a physician, says Doctor Walker. It just seemed a natural path to follow. He vividly remembers observing his first operation at the age of seven. "I stood on three stools to watch my father perform an appendectomy," recalls Doctor Walker, "but I'm sure I really didn't know what was going on." Later, Doctor Walker accompanied his father on house calls around the Detroit area during the 1940s and early 1950s. He still remembers his father's heated discussions about the Wagner-Murray-Dingell Bill, which called for a national health plan. "In a sense nothing has changed since then," he says. "The issues have just become more global."

Studying medicine at the Wayne State University School of Medicine, Doctor Walker broke with the family tradition of surgery and went into pathology. He explains he was initially drawn to pathology because of the science. Later, it was the constant variety and the whole learning process that kept him fascinated. "Essentially, the doctors are your patients," says Doctor Walker.

After completing medical school, Doctor Walker did a two-year stint in the airborne unit at Fort Campbell, Kentucky, followed by six years in the reserves. He went into private practice in Detroit before forming a medical corporation in 1968.

Doctor Walker has experienced many of the difficulties of trying to practice medicine in America today and sees organized medicine as a natural extension of practice. This is the arena to solve the issues that come up in practice, he explains.

His bid for a three-year term to the AMA Board of Trustees is a way of being a part of that arena and an important way of continuing to have a voice in medicine in the future. "The AMA will play an important role in health care reform in the future," predicts Doctor Walker, particularly since both Governor Clinton and President Bush have embraced aspects of the AMA Health Access America Plan.

Campaign goals

A major part of Doctor Walker's campaign will focus on increasing AMA membership. Currently, only 42 percent of physicians in the nation belong to the AMA. Doctor Walker remembers back in the sixties when membership was around 90 percent. Things have changed, he concedes. Specialty societies have developed, organization fees have increased; but he would still like to see membership pass the 50 percent mark by the year 2000.

Doctor Walker would like to see more incentives for physicians to join the AMA. "It is important to continually try to be innovative, to obtain the widest possible audience," he says. "If the AMA has the most physicians it has the strongest voice for negotiating. It is the power that comes from unity that is the greatest advantage of the AMA."

Doctor Walker is not blind to the difficulties of recruiting physicians to organized medicine. "Some phy-

sicians have the perception that they don't get anything for their AMA dues," he says. But, he stresses the most powerful benefits of membership are intangible -- like good legislation that benefits everyone. "They don't see that all the increased regulations that have been introduced over the last year -- RBRVS, OSHA and CLIA regulations -- could have been much worse without AMA input," he says. The nature of this business is negotiation and compromise, explains Doctor Walker, who counts the modified legislation as victories for the AMA.

On the personal side

For a man who juggles several projects at the same time, there is not much time for relaxation. Before he got busy Doctor Walker used to enjoy needlepoint. He started 30 years ago when he decided he wanted his dining room chairs covered in embroidery. Each seat cover was farmed out to the relatives and Doctor Walker began one himself. He became hooked. "I find it very relaxing," he says, "and easy to do while watching a game." His favorite item, however, is a needlepoint vest, which he admits with a sheepish smile, doesn't fit any more.

Doctor Walker's life is more than organized medicine. He is getting married on November 8 to Phyllis Fordon. "We have known each other for many years," says Doctor Walker. His first wife and mother of his four children, Virginia, died in 1990 after 35 years of marriage.

The new Mrs. Walker will have only a brief time to acclimate herself to her husband's hectic schedule before they head off to the December AMA Interim Meeting in Nashville, Tennessee, for a whole new round of resolutions, reports and campaigning. ■

Helen Fordham is chief of community relations for MSMS.



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VALUE ENHANCEMENT THE REAL CHALLENGE

By Fred Patterson, MD

We are now all too familiar with the phrase "cost containment." Every commentator, author and politician uses the phrase liberally when discussing the health care system in this country. But what does it mean?

To the senior citizen, it may mean restricted access, lower quality and greater out of pocket expense. To the business person it means no more cost increases and perhaps cost reductions for health care. To the physician, it can mean further fee reductions and involuntary discounts resulting in payments that may not cover expenses. To the politician it is a concept with popular appeal. Clearly, cost containment means different things to different people.

It is widely acknowledged that health care costs are too high, but few are willing to discuss or decide upon how much we should spend on health care. The ambitious efforts to achieve consensus on that important question in the state of Oregon have been widely criticized by people on all sides of the health care debate. We have all heard shock over the cost of a life saving technology or procedure, even from people who would willingly pay any price to have it available for themselves or their families.

A consensus definition of cost containment -- and a successful pro-



“ We need to answer questions about the services we provide:
Are they necessary?
Can we do them better?
Can we do them with less cost and not affect the result?
Are there other ways to achieve the same result?
What are the outcome probabilities? How can we improve on our results? ”

gram to achieve it -- has been very hard to develop. As I see it, the focus of discussion about health care should be about value rather than cost.

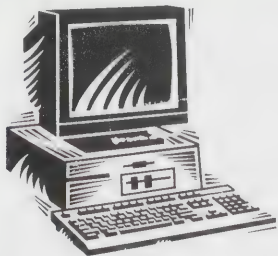
Value is an important consideration for all of us in our daily lives.

We shop for the best "value" in cars, clothes, etc. Advertisers remind us of the special "value" we will receive if we purchase their product over a competitor's. Why does one individual purchase a luxury car for transportation and another of equal means a basic car to serve the identical function? Perceived value. This is what gives quality to our lives.

Like quality, the concept of value is hard to define. There is, however, no need to attempt definition. Value is what an object, service or concept means to the buyer. For example, two patients have disabling osteoarthritis of the hip. One is an athlete and is unable to participate in his favorite sport. The other is so uncomfortable that he has difficulty with the activities of daily living. Both have successful total hip surgery. The dollar costs are identical. Which one should have his costs restrained? Who received the greatest value? The only person that can answer these questions fairly is the patient.

As physicians, we are well aware of the value of prevention. Many of us have committed time and resources to the development of guidelines and recommendations for preventative services. We know the value of healthy lifestyles, screening, early detection and edu-

Continued on following page



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Continued from page 31

cation in preventing costly illness or complications of chronic conditions. Yet, many purchasers choose to exclude coverage for preventative services from their benefit packages.

Focus on value needed

This is our challenge. We need to focus on "value enhancement." The dollar costs can then be put in perspective by the recipients and purchasers of our care.

Value enhancement means a critical evaluation of the elements of the services we perform. We need to answer questions about the services we provide: Are they necessary? Can we do them better? Can we do them with less cost and not affect the result? Are there other ways to achieve the same result? What are the outcome probabilities? How can we improve on our results? This evaluation process need not be limited to the traditional standards of care approach, but might best include details of our training, experience, availability and facilities.

To successfully sell our service as a value we should also try to understand the expectations of the patients and purchasers. By defining their expectations, we can either help them analyze and change their expectations or strive to meet them.

In the end, we should compete with one another in the arena of value. Whoever can provide the most value as perceived by those we serve will be rewarded.

Until we engage in this type of "selling," health care costs will be perceived as being too high. The purchasers will know the dollar cost of everything, but the value of nothing. We will continue to lack the resources necessary to provide adequate prevention and screening services.

By focusing on value, physicians can bring new meaning to discussions about health care affordability, access and quality. A workable health plan may actually emerge. ■

Doctor Patterson is a member of the MSMS Board of Directors and is chairman of the MSMS Advisory Committee on Medical Economics.

MEDICAL INQUIRER

DATA AND TRENDS AFFECTING MICHIGAN PHYSICIANS from the MSMS Department of Medical Economics and Health Care Delivery



Emergency Department Survey

The hospital emergency department not only treats the suddenly ill or injured, but is also the repository for many of the country's social problems. For the uninsured it is sometimes the only source of care for both routine and extraordinary health problems. Victims of accidents, violence or the sudden heart attack rely on the emergency department for fast response.

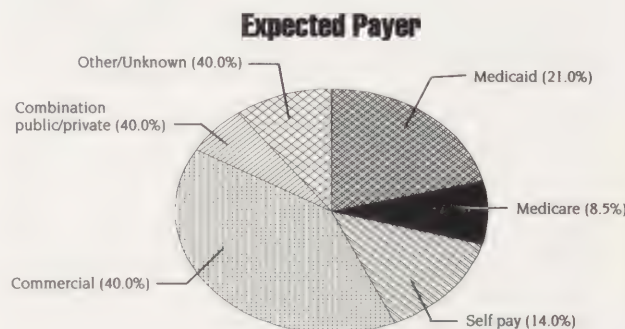
Emergency care is often the most expensive treatment however, and resources are wasted when ordinary care is delivered in the emergency department. In addition,

Emergency departments have the most sophisticated equipment available, yet many of the cases seen are somewhat routine. Forty-eight percent of visits were for reasons such as cuts, broken bones, back pain, colds and flu.

One-third of emergency visits had Medicare or Medicaid as the expected payers. Fourteen percent of patients were self pay, making full payment of services less likely.

tion, overcrowding of emergency departments is an increasing problem in urban areas. Part of this overload is attributed to the increasing violence and drug use in our society.

The Michigan Hospital Association and the Michigan College of Emergency Physicians surveyed emergency departments in 46 Michigan hospitals in 1991. Patient records for a 24-hour period were analyzed to determine the impact of social problems. The following statistics were reported from that survey.



Not surprisingly, urban emergency departments saw most of the violence-related admissions. Eighty-one percent of visits in this study were in urban areas. Alcohol, drugs, and mental instability were cited as potential causes in the vast majority of urban cases.

Urban emergency departments treated...

- 92% of gunshot wounds
- 100% of stab wounds
- 90% percent of drug overdose cases
- 89% of personal assault victims
- 89% of sexual assault victims

Auto accident victims were the most common admissions to rural emergency departments. Fractures, falls, flu and colds are also more common reasons for visits than in urban areas. Alcohol is the most frequently cited potential cause.

Rural emergency departments treated...

- 81% of patients over age 20
- 24% of accident victims
- fractures, falls, cold and flu symptoms most often

There were 24 gunshot wound victims treated in the 24 hour period. Nearly all victims were male and were treated in urban hospitals. More than half were self pay patients, increasing the odds that the hospital will never be reimbursed. One in four cases involved alcohol and one in six involved drugs.

Of 24 gunshot wound victims...

- 79% were male
- average age was 28
- 92% were treated in urban areas
- 25% had alcohol as an underlying factor
- 17% had drugs as an underlying factor
- 50% were self pay patients
- 21% were Medicaid patients

All 10 stab wound victims were treated in urban areas. Seventy percent were either self pay or Medicaid patients. Eight of the ten cases were male, and one-third involved alcohol.

Of 10 stab wound victims...

- 80% were male
- average age was 35
- 100% were in urban areas
- 30% had alcohol as an underlying factor
- 40% were self pay patients
- 30% were Medicaid patients

SOURCE: Kneisley, J, Clark, JD, Struthers, N., 1991 *Michigan Hospital Emergency Department Survey*. Michigan Hospital Association, August 1992.

For further on trends and sources of information, please contact Julie Lester at MSMS.

MSMS Survey on Medicare carrier problems revealing

By Willard Stawski, MD

Medicare physician payment reform unleashed a whole new set of policy changes for physicians and their staffs to learn in addition to the changing payment levels. But beyond the rules changes, there are servicing issues that have been a recurring source of concern for physicians. Issues such as elimination of the toll free lines, difficulty in getting through on the phone, and the expertise and availability of provider inquiry staff have been the source of physician complaints.

Blue Cross Blue Shield of Michigan (BCBSM) is the Medicare carrier for the state and has worked with MSMS over the past several years to resolve problems brought to its attention. Carrier medical director George R. Gerber, MD, regularly participates in subcommittee meetings and travels the state meeting with physicians.

Despite these efforts, some MSMS members have expressed concern that Michigan physicians were experiencing an unusual amount of problems with carrier operations. In 1991, a resolution was passed by the MSMS House of Delegates asking for exploration of alternative Medicare carriers. The resolution was assigned to the Subcommittee on Medicare Carriers, a subcommittee appointed by the Liaison Committee with BCBSM.

The research yielded details on the criteria the Health Care Financing Administration (HCFA) uses in evaluating each carrier and information from other state medical societies on experience with their carriers. The Subcommittee then recommended that MSMS collect specific information on the problems physicians were experiencing with Medicare.

A tearout survey was published in the June 2, 1992, and July 14, 1992, issues of *Medigram*, soliciting feedback on four areas: carrier communication, provider inquiry, timeliness of payment, and other miscellaneous issues. The results are based on 404 responses received by August 26, 1992.

After the Subcommittee reviewed the survey results, Doctor Gerber responded with current operations information and other pertinent details.

Poor communication a common complaint

One of the most frequent complaints received by the MSMS Reimbursement Ombudsman is that claims are sent to Medicare but are never acknowledged, and further inquiry reveals that Medicare has no record of the claim. Seventy-two percent indicated that they had



Doctor Stawski

“MSMS, through the Board of Directors, the Subcommittee on Medicare Carrier and other avenues, will continue to press for remedies that help physicians cope with both the policy and the operational issues.”

experienced such a problem, and an average of 10 percent of their claims were “lost.” Forty percent said that they frequently sent letters or inquiries to Medicare that also were not acknowledged.

The average Medicare response time to letters or inquiries was 10.9 weeks as reported by respondents. When asked about the timeliness of information on Medicare policy changes, 48 percent rated the timeliness of information on Medicare policy changes as good or excellent, 39 percent rated it fair, and 13 percent rated it poor. When asked about the effectiveness of the publications that relayed those policy changes, 46 percent rated them good or excellent, 43 percent fair and 11 percent poor.

The “lost claim” problem can be attributed to lack of knowledge about using the response file available to offices that submit electronically, according to Doctor Gerber. If any of several critical pieces of information are missing from any claims submitted electronically, the host computer will not accept them at all. In that case, they are never officially received by BCBSM/Medicare and do not appear in their files.

A response file details any claims that were not accepted at the first step due to these missing elements. If offices do not know how to use the file or do not routinely check it, they may think claims were submitted when they actually were not. Each computer vendor has a different protocol for accessing the response file, so education on this issue is problematic. The Reimbursement Roundup column in the September issue of *Michigan Medicine* gives more detail on using the response file.

Continued on following page

Provider inquiry improving

Respondents had called Provider Inquiry within the last month on average. Respondents stated that they had to call back a second time to get past the busy signal 62 percent of the time, and they had to call back a third time 50 percent of the time. The average time on hold once they got through was nine minutes. Eighty-eight percent reported that the Medicare service representative routinely identified him/herself by name. However 93 percent of respondents stated that they worked with a different representative each time, making continuity a problem. Fifty-seven percent stated that they always or usually get specific answers to their questions, while 37 percent stated that they rarely did and six percent said they never did.

Current operations data from BCBSM/Medicare show that 97 percent of calls are answered in less than two minutes. Last year, all incoming lines were busy 85 percent of the time; this year that problem occurs only 0.4 percent of the time. This improvement is due to several changes. The carrier has doubled the number of personnel on phone lines and has another five positions budgeted for the coming fiscal year. In May 1991, an automated response unit (ARU) was instituted, allowing callers to choose from menu options for certain types of inquiries. According to Doctor Gerber, the ARU handles 20 percent of the incoming calls.

Timeliness of payment usually slow

Average reported payment time was 32 days for Medicare and 28 days for other payers. Fifty-seven percent stated that they had noticed unusual payment delays from January to March of this year when compared to the same time last year, and the average increase in payment time was five weeks.

Other issues

HCFA sometimes requires the carrier to ask physicians to rebill claims that were rejected incorrectly due to some error in computer programming or other causes, thereby shifting the cost of the mistake to the physician, rather than authorizing funds to have staff correct the problem. Respondents reported that of the claims that had to be resubmitted, 20 percent were due to no error on their part.

Eleven percent thought that the Medicare audit criteria were clearly defined, and 55 percent said they were somewhat vague, while 34 percent did not know or had no impression.

New carrier initiatives

In addition to the changes already instituted by the carrier, several new projects are being considered or

tested. A provider outreach program began in April, which identifies providers or provider groups that have a large volume of inquiries. BCBSM/Medicare staff now periodically contact these providers for assistance. The carrier hopes this type of intervention will more efficiently handle providers that make many inquiries.

The carrier is also planning a pilot program in November which would bring the Dial-In Eligibility Network Information System (DENIS) to the Medicare program. DENIS is currently available on the regular business side for checking eligibility or claims status by computer. A pilot program for the claims status portion on DENIS is already planned, and the carrier is currently awaiting official approval from HCFA for the eligibility portion. It is expected that this program will reduce the number of inquiries.

Another pilot program that has already begun allows informal reviews to be conducted over the phone for a limited number of providers. This project will be expanded to other providers in the new fiscal year.

Future challenges

Selecting an alternative carrier for Michigan is in some ways an academic discussion. HCFA is clearly headed toward further regionalization of services, and they will award contracts based on the ability to do the work for the lowest cost per claim. As the federal health budget suffers increasing scrutiny, HCFA will demand more and more from the carriers while allocating fewer dollars to do the job. Flexibility is also a problem -- the carrier budget is a line-item budget, and money saved in one area cannot be redirected. Although continued work with the carrier on improved servicing is necessary, the other challenge is to get HCFA to realize that physicians are customers with legitimate concerns about the system. The types of issues outlined above are likely to continue to be of concern regardless of what HCFA does with regionalization.

MSMS has not received the most recent carrier performance report yet, and will be reviewing it with the appropriate committees. The Board of Directors has asked for an examination of the pros and cons of regionalization and has expressed concern that Michigan physicians could be worse off under a regional carrier located outside the state. MSMS, through the Board of Directors, the Subcommittee on Medicare Carriers and other avenues, will continue to press for remedies that help physicians cope with both the policy and the operational issues. ■

Doctor Stawski is chairman of the Medicare Carrier Subcommittee, a subcommittee of the MSMS Liaison Committee with Blue Cross Blue Shield of Michigan. He is also a member of the MSMS Board of Directors.

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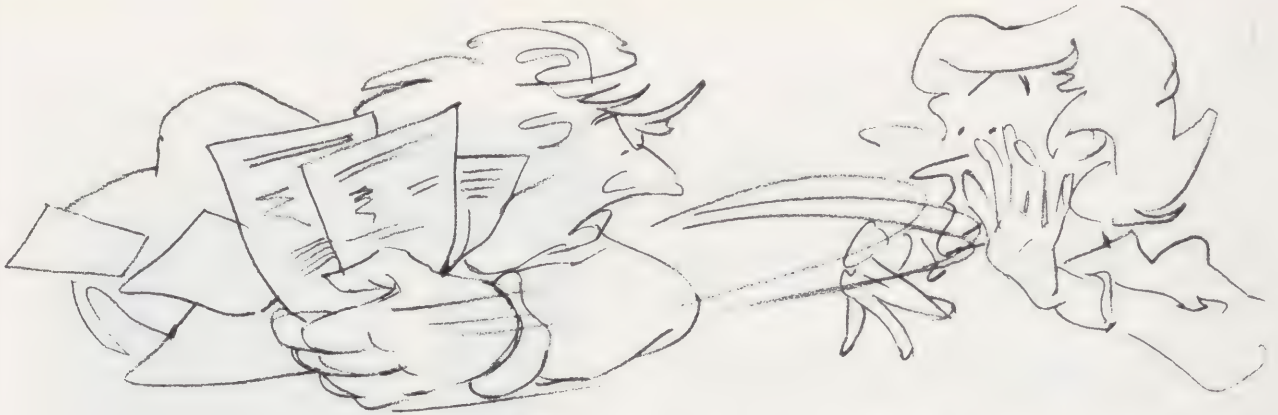


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JUDICIAL COMMISSION & RISK MANAGEMENT

Commission routinely receives questions, complaints about access to medical records

By Helen Fordham

My doctor won't let me have my medical records, Mary Smith wailed plaintively into the phone. His employees are rude, too, she added, and they make me wait for ages to see the doctor.

Mary Smith is not alone in her complaints about physicians. Nor are her lamentations particularly unique. The most frequent complaints the Michigan State Medical Society receives about physicians is that fees are too high, patients can't get their medical records and that physician office staffs are rude and disrespectful.

"MSMS receives about 25 calls a week from patients unhappy with the way they have been treated by their physician and his or her staff," says Sherry Fent, manager, MSMS Department of Administration and Physician Education. "Most are straightforward complaints but they can lead to larger problems, including litigation, if they are not dealt with promptly," she explains.

Handling complaints can be difficult

Although the Board of Medicine enforces medical law in Michigan in accordance with the Public Health Code, dealing with complaints about physicians can be difficult since aspects of their conduct are regulated by ethics rather than laws. "Every physician is expected to behave in an ethical manner," explains George Morley, MD, chairman of the MSMS Judicial Commission. "Yet there is no way to enforce ethical behavior."

One medical society mechanism for monitoring physician behavior and dealing with complaints is the MSMS Judicial Commission and the ethics committees of the various county medical societies. The commission and committees have jurisdiction over matters

relating to professional ethics grievances, mediation, discipline of members and professional conduct.

"The Judicial Commission and the ethics committees not only investigate complaints lodged by fellow physicians but also afford the public an informal means of making known to the profession any alleged grievance arising from the physician-patient relationship," explains Doctor Morley. He added the Commission provides an opportunity for patients to resolve disputes with physicians without resorting to litigation.

The standard procedure for complaints is to ascertain that the physician is a member of the medical society and then refer the complaint to the county level. The complaint is investigated there. If the physician is found to have acted unethically, consequences can range from a reprimand to expulsion from the medical society. "The Commission has no legal power to penalize unethical behavior," says Doctor Morley, "but it can make recommendations to the Board of Medicine that a license be revoked." If either the patient or physician is unhappy with the outcome, then the issue may be referred back to the MSMS Judicial Commission for further investigation.

Complaints MSMS receives about physicians range from sexual misconduct to negligence, both of which violate the law. But reports of these more egregious cases are infrequent, says Fent.

"We do receive a number of calls from patients complaining about physicians' hygiene practices," says Fent, adding that many patients are concerned with the spread of AIDs and other communicable diseases.

By far the most common complaint MSMS receives from the public about physicians, according to Fent, concerns the physicians' refusal to release a patient's medical record, particularly if there is an outstanding bill.

According to the AMA *Current Opinions* of the AMA Council on Ethical and Judicial Affairs, it is considered unethical to withhold a patient's record because of an outstanding bill. What's more, in Michigan it is against the law for a physician to deny a patient access to their records, except when the records relate to mental health. The law states that although the paper the medical records are written on belongs to the physician the patient has legal access to the information.

Yet some physicians do not appear to know this, says Fent. "Not giving patients access to their records can leave a physician open to liability," she explains. "If a patient does not receive correct care because a physician withholds records, then there is a risk they will be held responsible for any unfavorable outcomes."

"It is much simpler to write off the amount rather than risk a several hundred thousand dollar law suit," advises Julie Smith, chief of risk management for MSMS.

A registered RN with several years of experience as a liability manager, Smith holds seminars around the state on how to reduce physician liability. She hears complaints about office procedure from the physicians' perspective and she recommends that the small battles with patients over records are not worth the ill will they create.

Another common complaint Fent hears is that physicians' office staffs are rude. Patients call if they feel they have been treated discourteously and not listened to, she says.

Smith says the importance of office staff in averting complaints and possible litigation cannot be understated. "Office staff impact how patients feel about their health care," she says. Patients spend 70 percent of their time in a physician's office with the staff, so they develop their impression of the doctor from how the staff treat them. "If a patient is treated well and their questions are answered adequately, they tend to like their physician and see him or her as a good doctor," she says.

Taking the time to build a rapport with a patient translates into direct advantage for the physician, adds Smith. According to recent studies, patients who like their physician are less likely to sue even in the event of an adverse outcome. "The extra five minutes you spend effectively communicating with the patient could save a law suit," says Smith.

As part of building rapport, it is important that patients have access to their physicians, says Smith. MSMS has received complaints from patients who claim that office staff refuse to allow them to speak with the physician. If a patient feels he or she is being prevented from speaking to the physician they can allege abandonment, Smith explains. Physicians should set limits on the gatekeeping capacity of the receptionist.

"Many problems with patients could be averted," says Smith, "if the office staff or physicians take the time to effectively communicate and establish a good rapport with the patients." ■

Helen Fordham is chief of community relations for MSMS.

Ownership of Medical Records

The following was ruled by the Attorney General of Michigan on May 30, 1978, opinion no. 5125:

1. The patient information contained in the medical records is the patient's property.
 - a. The patient has a right to access this information and a right to obtain a copy of the information within the record.
 - b. The health care provider may implement policies for patient viewing of records which do not interfere with the normal routine.
2. The health care provider owns the "hard copy" original.
 - a. The health care provider will determine forms and information to be placed in the record.
 - i. MCL 333.20175 requires the health care provider maintain a full and complete record for each patient.

MSMS Judicial Commission

The MSMS Judicial Commission has general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline of members and professional conduct generally. The following physicians, elected by voting members of the Society, currently serve on the Commission:

Edwin H. Gullekson, MD
Flint

Cecil R. Jonas, MD
Southfield

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Detroit

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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3535 W. 13 Mile Rd., #632
Royal Oak 48073

Mohan V. Achwol, MD -AN
1011 Patrick #19
Flint 48503

E. Stanton Adkins, MD -PDS/GS
15417 Essex
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3555 Clovertree Lane
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Kaleem Ahmed, MD -IM/GE
3106 S. Wayne Rd.
Wayne 48184

Muhammad K. Ahmed, MD
292 E. Chicago St.
Coldwater 49036

Jamal Uddin Akbar, MD
2765 Flushing Rd.
206 Flint Medical Arts Bldg.
Flint 48504

Hussein Z. Akl, MD
509 Hazen Street
Paw Paw 49079

Scott T. Aldridge, MD -FP
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Drummond Island 49726

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1810 W. Washington, Ste. 1B
Greenville 48838

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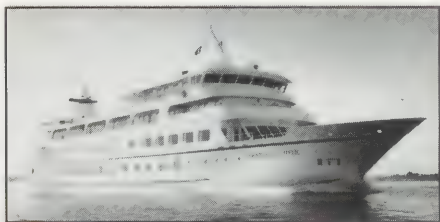
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MEETINGS

MSMS Meetings

November

16, Public Symposium on Family Violence, Hyatt Regency, Dearborn, MI. Contact: Judy Marr, Manager, MSMS Department of Communications and Professional Relations, (517) 337-1351.

16, MSMS AIDS Speakers' Bureau Update. Hyatt Regency, Dearborn, MI. Contact: Tracy Baker, MSMS Coordinator AIDS Provider Education Project, (517) 336-5770.

17, "A Conversation with Ann Jillian," Hyatt Regency, Dearborn, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

17-19, MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 337-1351.

17, 18, 19, 20, MSMS/AMA Medical

Office Staff Series, Hyatt Regency, Dearborn, MI. Contact: Office of Physician Education, (517) 336-5784.

December

3-4, MSMS Practice Management Seminar, "New Medical Biller Training Series-Medicare," Pretzel Bell Restaurant, East Lansing, MI. Contact: Angela LaBonville, MSMS Department of Medical Economics, (517) 336-5723.

7, 9, 10, MSMS/MPMLC Risk Management "The Legal Pitfalls Surrounding AIDS," December 7th, Park Place Hotel, Traverse City, MI; December 9th, East Lansing, MI; December 10th, Novi Hilton, Novi, MI. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

January

7-8, MSMS Practice Management Seminar, "New Medical Biller Training Series-Medicaid," Pretzel Bell Restaurant, East

Lansing, MI. Contact: Angela LaBonville, MSMS Department of Medical Economics, (517) 336-5723.

February

2-6, MSMS/MPMLC Risk Management Winter Conference, "Safeguarding Your Future," Keystone Resort, CO. Contact: Julie Smith, MSMS Chief, Risk Management, (517) 337-1351.

4-5, MSMS Practice Management Seminar, "New Medical Biller Training Series-Commercial Carriers and Managed Care Programs," Pretzel Bell Restaurant, East Lansing, MI. Contact: Angela LaBonville, MSMS Department of Medical Economics, (517) 336-5723.

March

12-14, MSMS Joint Section Annual Meeting, Radisson on the Lake, Ypsilanti MI. Contact: Judy Marr, Manager, MSMS Department of Communications and Professional Relations, (517) 337-1351.

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MEETINGS

24-25, MSMS Maternal Health Care Conference, Holiday Inn South, Lansing, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

April

30-May 3, MSMS House of Delegates, Ritz Carlton, Dearborn, MI. Contact: Donna Farougi, Coordinator, Special Programs, (517) 336-5735.

July

14-18, MSMS Midsummer Board Meeting, Shanty Creek, Bellaire, MI. Bill Madigan, MSMS Executive Director, (517) 336-5734.

November

9-11, MSMS Annual Scientific Meeting, Westin Hotel, Detroit, MI. Contact: Sarah Cressman, MSMS Assistant for Physician Education, (517) 336-5727.

AMA Meetings

December

3-9, AMA Interim Meeting, Opryland Hotel, Nashville, TN. Contact: Judy Marr, MSMS Manager, Department of Communications and Professional Relations, (517) 337-1351.

June

10-17, AMA House of Delegates, Chicago, IL. Contact: Judy Marr, Manager, MSMS Department of Communications and Professional Relations, (517) 337-1351.

National Specialty Society Meetings

October


29-31, American Society of Bariatric Physicians, Westin Hotel, Chicago, Ill. Contact: (303) 779-4833.

Other Meetings

March

7-14, Midwest Doctors Medical Seminars, Snowmass Village, Colorado. Contact: Richard Campau, Michigan State Medical Society, (517) 337-1351.

8-13, Thirteenth Annual Mammoth Mountain Emergency Medicine Ski Conference. Contact: Mark Song, MD (714) 552-0831.



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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least three hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

November

12-13, Neonatology 1972-1992, Twenty Years of Problems, Progress, and Prospects. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Pediatrics. **Contact:** Robin Rice, Registrar, Towsley Center for Continuing Medical Education, Department of Post Graduate Medicine, University of Michigan

Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 12.5 hours Category I Credit.

December

4-5, Women's Health Care for the Primary Care Provider. **Location:** Towsley Center, University of Michigan, Ann Arbor, Michigan. **Sponsor:** University of Michigan Medical School, Department of Family Practice, Department of Obstetrics and Gynecology. **Contact:** Robin Rice, Registrar Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 14.5 hours Category I Credit.

11-12, Psychiatry Update 1992: Medical Science for Psychiatrists. **Location:** Towsley Center, Ann Arbor, Michigan. **Sponsor:** University of

Michigan Medical School. **Contact:** Robin Rice, Towsley Center for Continuing Medical Education, Department of Postgraduate Medicine and Health Care Professions, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106, (313) 763-1400. **Approved for:** 13 hours Category I Credit.

13, Urban Medicine Symposium III. **Location:** Hotel St. Regis, Detroit, Michigan. **Sponsor:** Wayne State University School of Medicine, Department of Family Medicine, Michigan Health Center, and the Detroit Health Department. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, University Health Center, 4201 St. Antoine, 4-H, Detroit, MI 48201, (313) 577-1180. **Approved for:** 6 hours Category I Credit.



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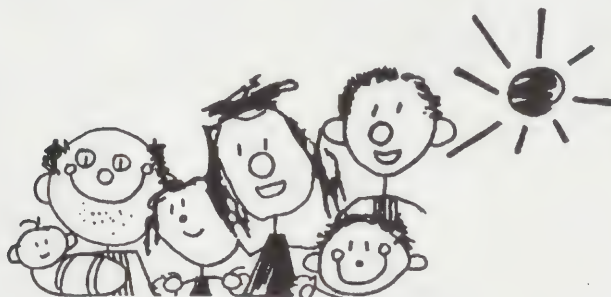


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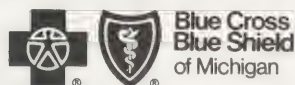
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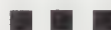
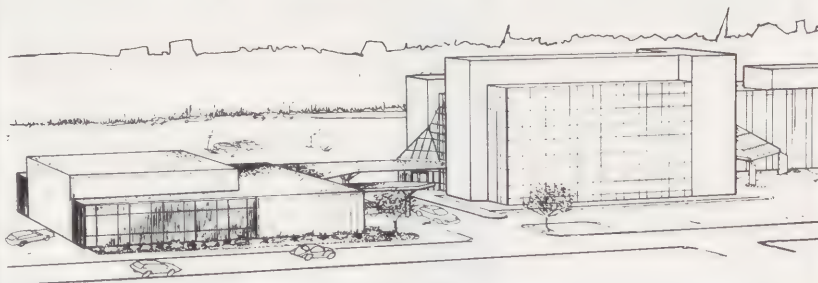
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Continued from page 51

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President's Page

Continued from page 56

should strive for 100 percent. If you attend your county society meetings, plan to bring a resident or a new physician in your community. Encourage them to join and tell them why. If your county does not meet regularly, find out why and see if you can do something to put the meetings back on track. Stay up on MSMS activities by reading *Medigram* and *Michigan Medicine*. If you need a quick refresher on everything MSMS has done in the past year and what we plan to do next, take an hour to thoroughly reread the August issue of *Michigan Medicine* which covers the activities of our House of Delegates. You will find that an awful lot of dedicated individuals are working hard and spending a lot of time and energy on your behalf.

It's just like being a responsible citizen of our country. It is up to you

to inform yourself, get the facts, and then pursue your philosophy through voting, writing letters to state and national senators and representatives, supporting candidates, working within the system to get your goals accomplished.

Of course, sometimes it's easier to sit on the sidelines and take potshots at those who are trying to get something done.

We must guard against this within our own system. We must work for our profession and our patients within the framework of organized medicine. The forces allied against us are real and powerful. We must be committed to our profession, we must give back to our communities and we must become involved members of organized medicine.

Now, more than ever, we must hang together. You know what happens if we don't. ■

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Now, more than ever, we physicians must hang together

By Thomas C. Payne, MD

Think of the fear, excitement, courage, frustration and agony felt by representatives of the 13 American colonies as they signed the Declaration of Independence from Great Britain a couple of centuries ago.

With ink dripping from his pen, one of their wisest and most-often quoted members, Benjamin Franklin, turned to the gathering and said, "We must all hang together, or assuredly we shall hang separately."

Students of American history will remember that this group was far from monolithic in its opinions and, in fact, was quite acrimonious in its deliberations, particularly as it developed the Constitution. The big states wanted things one way, the little states another way.

But for all of their bickering, they did not forget their overriding mission: to begin a bold experiment in representative government and to establish a new, independent country that would allow life, liberty and the pursuit of happiness.

In the ensuing 216 years, the bickering has never ceased. We have gone in one direction, and then another, as opinions and circumstances changed.

We continue to evolve and change as our society develops. But there have always been two constants. One is the undeclared agreement that our citizens will work within the framework of government that has proven effective for nearly 10 generations. The second is that citizens will take seriously their responsibilities *as citizens* to make the system work.

This is a lot like organized medicine. I do not believe a more democratic system within a pro-

fessional association exists anywhere. Our form of policymaking nearly mirrors the US system. In fact, in many ways, our system is even more responsive. Of course, our system, too, is predicated on the fact that we have active members.

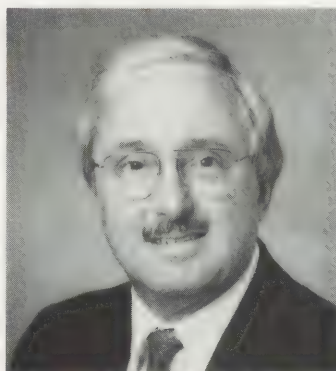
Our state delegates represent local physicians at our House of Delegates and then our delegates to the American Medical Association represent Michigan physicians at the AMA meetings. Any physician on the grassroots level may submit a resolution for consideration by the MSMS House and then, if successful, by the AMA.

But resolutions are only one way to affect the direction of organized medicine. County societies are wide open for participation by any physician with the will and the energy to get something done. As I mentioned in my inaugural address, all you have to remember is PRIDE -- participation, representation, involvement, dedication and environment. Participate in activities on your county level; represent your profession on local community groups; involve yourself in state medical society activities; dedicate a little time and energy and maybe some money to local and state political activities; and finally, help the environment of your community through addressing the ubiquitous problem of domestic abuse.

These are just a few ideas of where you can get started in organized medicine. Sit back and think about *your* areas of interest and pursue them through your county and state society.

Those of you reading this obviously already are members of MSMS. We have about 80 percent of the medical doctors in Michigan as members. We

Continued on page 55



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‡Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control mild heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbo KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbo K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1° 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain; claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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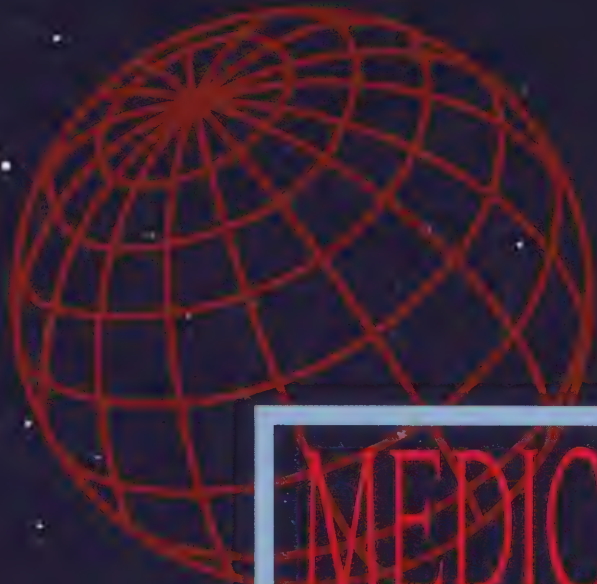
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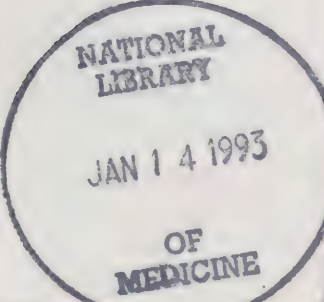
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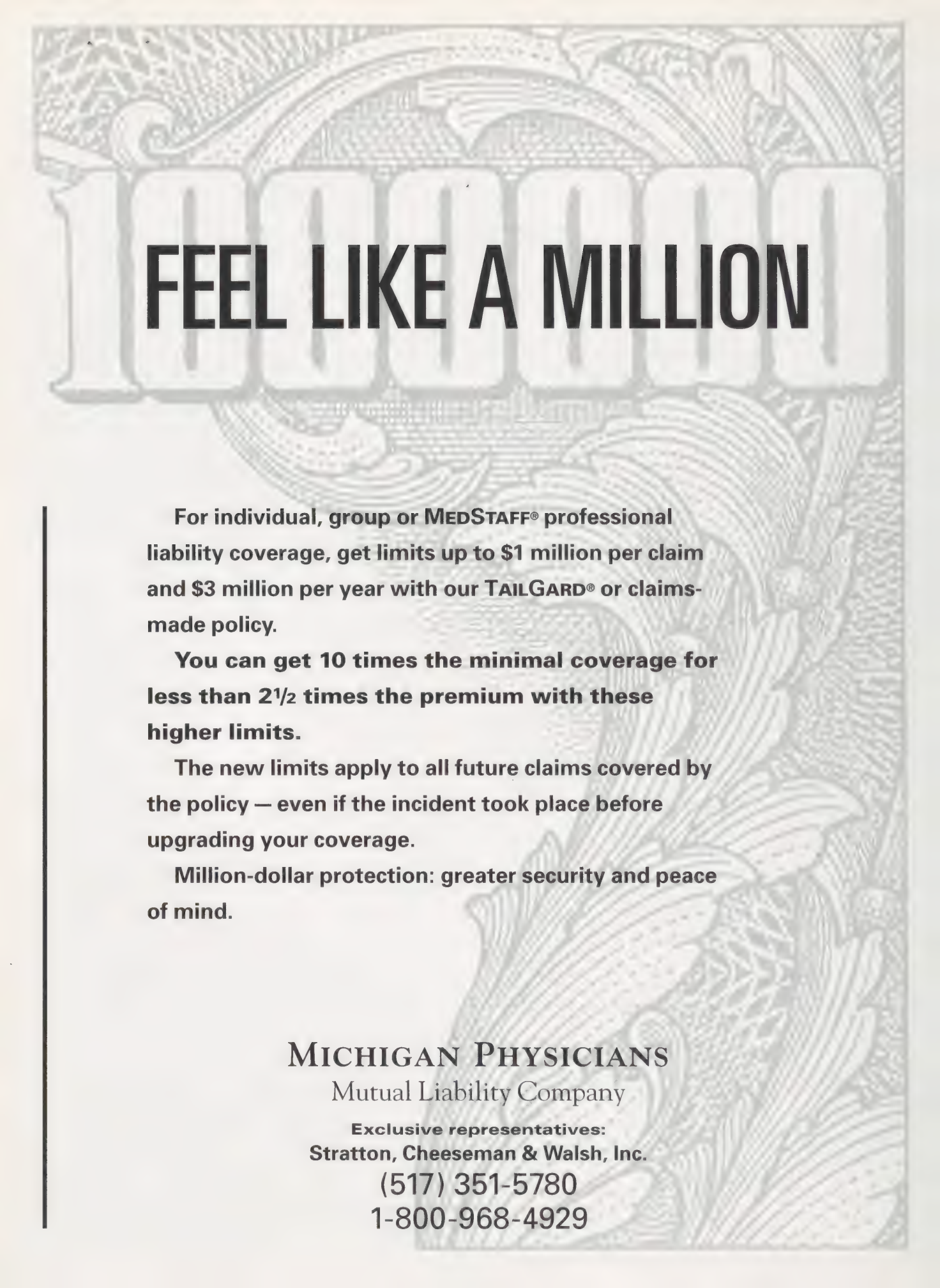
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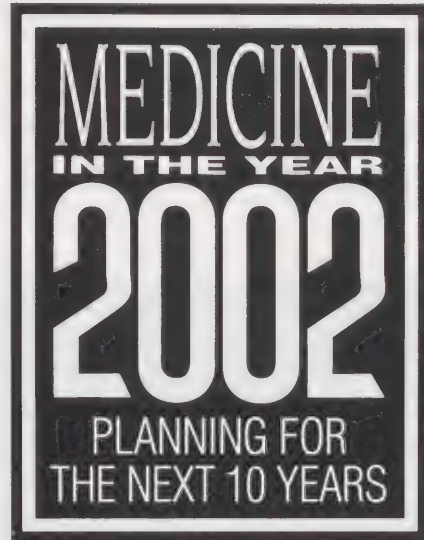
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Award-Winning Journal of the Michigan State Medical Society

MEDICINE IN THE YEAR 2002

"If you do not think about the future, you cannot have one," said the famous author John Galsworthy. To help physicians think about the future and start to prepare for what lies ahead, MSMS recently held a series of focus groups around the state on "Medicine in the Year 2002." A select group of approximately 50 Michigan physicians -- representing various ages, specialties, ethnic backgrounds and geographical locations -- were asked a series of questions on various health care topics and how they thought they would evolve over the next 10 years. Out of these focus group discussions, and the written responses of those physicians not able to participate in the focus groups, came a glimpse of the challenges and opportunities which lie ahead. This month's issue of *Michigan Medicine* is devoted entirely to the results of this "Medicine in the Year 2002" project. Also included is an examination of the AMA's Health Access America plan and how it compares to the health care plan of President-Elect Bill Clinton.



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Start Planning Now

Your future is in your hands

By Betty J. McNerney, Editor

"If you do not think about the future, you cannot have one," said the famous author John Galsworthy. With a new decade, a new century, a new millennium close at hand, one cannot help but feel a sense of anticipation and mystery. As one of the editors of *Time* magazine recently wrote, "the year 2000 has always been so symbolic of an idealized future, the better world that we'd like to see. Considering the rapid pace of change, we can't predict all the news that the 21st century will bring, but many challenges and opportunities are already coming into view."

To help physicians think about the future and start to prepare for what lies ahead, MSMS recently held a series of focus groups around the state on "Medicine in the Year 2002." A select group of 50 Michigan physicians -- representing various ages, specialties, ethnic backgrounds, geographical locations and, of course, both sexes -- were asked a series of questions on various health care topics and how they thought they would evolve over the next 10 years. Questions addressed these subjects: specialists, pri-

mary care physicians, and other health professionals; medical liability; practice management; public health; medical ethics; health care reform; clinical issues; demographics; medical education; and physician image.

Out of these focus group discussions, and the written responses of those physicians not able to participate in the focus groups, came a glimpse of the many challenges and opportunities which lie ahead.

This issue of *Michigan Medicine* is devoted to the results of our "Medicine in the Year 2002" project. Rather than paraphrasing or summarizing the comments of those who participated in this project, though that has been done to a certain degree, this issue features several direct quotes -- quotes that are thought-provoking, profound, emotionally charged and deeply felt. It is my hope that you will read this issue and then decide to take an active role in shaping the future of medicine in this state. MSMS stands ready to assist you.

I am grateful to have had the experience of discussing the future of medicine with so many caring and dedicated physicians, and I thank each and every one of them who took time out of their busy schedules to participate in this project. I also must thank Peter Pratt, senior health policy consultant for Public Sector Consultants, who served as moderator of the focus groups. To work with such a knowledgeable and talented person was an honor and a privilege. Last, but not least, I would like to thank Julie Lester, chief of health care research for MSMS, for her participation and guidance throughout this project. ►



Listening to Physicians Talk About the Future of Medicine

By Peter Pratt

Editor's note: Peter Pratt, senior health policy consultant for Public Sector Consultants, Inc., a Lansing "think tank," served as moderator of five focus groups held across the state. Following are his impressions of the discussions.

When the Michigan State Medical Society approached me about moderating focus groups in which physicians would discuss the shape of their profession and health care in the year 2002, I jumped at the chance. As a researcher and analyst, I am much more accustomed to

"I could not help but notice that a deeper resolve and commitment lay at the heart of their sense of the future of the profession. The more pessimistic the forecast, the more the physician was compelled to make one thing clear: that medicine would never be anything but a noble profession."

tracking the seismic shifts in health care delivery and financing; 50,000 physicians have to do something or have something done to them before it registers in my office. An outsider is not often afforded the opportunity to listen to 34 doctors describe how health policy plays itself out in their lives.

The five focus groups provided a fair share of surprises and fascinating perspectives. This was expected, as most of the participants came from a generation of physicians with which I was not familiar. (The physicians I know well are either friends of my parents, and thus retired, or my contemporaries, and thus relatively new to the world beyond residency.) Many of these physicians, then, have been in practice long enough to have been witness to both the "good old days" of physician autonomy and the less promising recent years of cumbersome acronyms and oversight. They are unique to the profession; no one before or after them will have quite the same perspectives.

Generational outlooks varied

None of the sessions lacked a variety of viewpoints. While consensus could be found in some areas, this hardly meant unanimity. When one physician lamented the failure of organized medicine to speak with a single voice, I could not help but think that this was increasingly difficult. The generational outlooks within the profession are quite different, as are the perspectives of various specialists. And it cannot be ignored that changes in reimbursement threaten to pit physician against physician in ways unimaginable just a few years ago.

Still, the tenor of the focus group discussions convinced me that diversity of perspective can sustain the medical profession in the difficult times ahead. The atmosphere of

each focus group was, paradoxically, intense and convivial. It was obvious that many of the participants could disagree and then walk out of the room and work well together. This mutual respect must be built upon if the profession is to do what is best for itself and, more important, for patients in the coming decade. Medicine can strengthen itself by admitting new voices into the fold. Diversity must not be seen as heresy but rather as the wealth of experience that professionals can bring to discussions of reform.

Almost without exception, physicians saw the constraints imposed upon the profession from the outside increasing in the next decade. The pressure to contain costs, the oversight by payers and regulators, and more wedges between doctor and patient came up again and again. The discussions of medical liability reflected many physicians' frustration about the issue. Weary from the endless pitched battle with the trial lawyers, few were able to foresee an end to the liability conflict.

Except for the talk of medical liability, however, any pessimism was belied by the tones in which it was expressed.

Commitment to profession strong

I heard little resignation, let alone despair. I was at first tempted to attribute the matter-of-fact replies to acquiescence. But later I came to a different conclusion. I could not help but notice that a deeper resolve and commitment lay at the heart of their sense of the future of the profession. The more pessimistic the forecast, the more the physician was compelled to make one thing clear: that medicine would never be anything but a noble profession. If they could do it all over again, they would go into medicine.

In this context, it should not be surprising that some changes in the profession were welcome. The computerization of the office and the promise of genetics had many waxing poetic. The opportunity to work

“Much trepidation was reserved for rationing, which many believe imminent. In fact, every focus group agreed that rationing would be the central ethical issue of the next decade. It came up first in every discussion of medical ethics. Many feared the moral quagmire that restricted autonomy presented to physicians, committed on the one hand to addressing patients' health needs without regard for cost and handcuffed on the other hand by payers who have decided that certain treatments will not be covered under any circumstances.”

more closely with other physicians and other health professionals in multispecialty group practices seemed to offer a measure of relief from the stresses of solo practice. More than a few were ready to help

usher in an era when the physician would become much more involved in prevention of disease and injury and issues of public health.

Rationing to be the ethical issue

This does not mean that physicians saw the year 2002 as a time of fewer challenges. Much trepidation was reserved for rationing, which many believe imminent. In fact, every focus group agreed that rationing would be the central ethical issue of the next decade. It came up first in every discussion of medical ethics. Many feared the moral quagmire that restricted autonomy presented to physicians, committed on the one hand to addressing patients' health needs without regard for cost and handcuffed on the other hand by payers who have decided that certain treatments will not be covered under any circumstances.

The intensity and liveliness of discussion was undiminished for the last question, on the public's perception of the physician in the year 2002. Several stated candidly that physicians themselves, regardless of pressures from outside the profession, have ultimate control over the public's perception of them. Some called for a stronger commitment to the welfare of the patient, a tacit admission that the profession had sometimes strayed from its role as patient advocate to fight too conspicuously for principles that appeared self-serving to the public. I was struck by the strong sense of responsibility for their patients that many of the physicians quite clearly felt. Even with all the hassles and fears and frustrations, that was, and in 10 years will still be, the bottom line. ■

Physician Dialogue an Important First Step

By Julie Lester

Editor's note: Julie Lester, chief of health care research for MSMS, played an integral role in the development of this project. In addition to helping formulate the questions on "Medicine in the Year 2002," she also staffed all five focus groups. Following are her impressions of the discussions.

“The theme of tradeoffs, willing or unwilling, was repeated throughout the discussions: trading a solution for medical liability for some sort of system reform, or trading relief from administrative hassles for a large group practice or salaried position.”

Although these focus groups were intended to stimulate physicians to think about the future, they also had the side benefit of making me think about what physicians face right now. Dealing with problems on a topic-by-topic basis gives you insight on particular areas, but it is easy to forget that Medicare or OSHA are just a few of the changes that physician practices are experiencing. Other than providing a more global framework to use in the future, particular ideas stood out in these groups.

The theme of tradeoffs, willing or unwilling, was repeated throughout the discussions: trading a solution for medical liability for some sort of system reform, or trading relief from administrative hassles for a large group practice or salaried position. Some physicians felt that the twin burdens of liability and paperwork would make more physicians accepting of a less traditional practice arrangement. It is also a foregone conclusion that the solo practice has gone the way of the family farm: fondly remembered and all but extinct in a few more years.

On a more positive note, public health was an area where many physicians agreed that patient relations could be improved and where both cost savings and better health outcomes could be achieved. Many regarded this as a way to prove to the public that physicians care about the health of their patients. Some physicians felt that they must educate their patients about the prob-

lems of the system as well, so that they fully realize the impact of the liability problem and are prepared for the hard choices that face us under any kind of meaningful system reform.

Rationing of care was an issue that surfaced repeatedly, as the predominant ethical issue of the new millennium and a problem for which physicians might take the blame if the public is not educated about the tradeoffs. One physician also raised the point that rationing should not occur until the administrative waste is removed from the system.

Much of the speculation was rather pessimistic, which was understandable given the turbulent nature of the current environment. But many expressed pride in their profession and a few even thought that things would be better (although quite different) once we had gotten through this phase. Clearly, there is a professional "sandwich generation," caught between their expectations based on the old system and the lack of control they feel during this evolutionary process.

This dialogue is only the beginning, and something more significant than this brainstorming/group therapy needs to happen before physicians will begin to feel more secure about the future. But it was an important start to sorting out ideas and sharing common problems, and it definitely reinforced in my mind that there are many thoughtful, concerned physicians out there to help shape the future of medicine. ■

Focus Groups Revealed Many Concerns, Hopes for the Future

Thirty-two physicians participated in focus group discussions held across the state as part of our "Medicine in the Year 2002" project. Two focus groups, which drew physicians from both the upper and lower peninsulas of Michigan, were held on Mackinac Island. The remaining three focus groups were held in Flint, Grand Rapids and East Lansing. Following are photo highlights of three of the focus groups.



Nine northern Michigan physicians participated in a focus group held September 20 on Mackinac Island. They were: Busharat Ahmad, MD; John Faughnan, MD; Carl F. Hammerstrom, MD; Carol Kreig, MD; Emily Lagace, MD; John Petrasky, MD; Kenneth Rowe, MD; Ali Sawaf, MD; and Satish Shah, MD.



Four physicians participated in a second focus group held September 19 on Mackinac Island. They were: John Bannow, MD; St. Joseph; Donald Beam, MD, Zeeland; Phillip Frantzis, MD, Jackson; Niranjana Lal, MD, Kalamazoo.



Six physicians participated in a focus group held October 14 in Flint. They were: Carlo A. Dall'Olmo, MD; Peter A. Duhamel, MD; Appa Rao Mukkamala, MD; W. Archibald Piper, MD; Frederick W. Sherrin, MD; and Allen Turcke, MD.

Eight physicians participated in a focus group held September 30 in East Lansing. Five others participated in a focus group held October 12 in Grand Rapids. Those who attended the East Lansing focus group were: Tama Abel, MD; John R. Addy, MD; Michael D. Chafty, MD; Mark Kolins, MD;

Douglas A. Mack, MD; Joseph Moore, MD; Michael J. Parks, MD; and Craig A. Wheeler. Those who attended the Grand Rapids focus group were: James V. Buzzitta, MD; R. Jack Chase, MD; Patrick Droste, MD; Charles R. Henry, MD; and Willard S. Stawski, MD.

Health Access America

The AMA proposal to improve access to affordable, quality health care.

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Simply, *Health Access America* proposes health insurance coverage

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To get a copy of the *Health Access America* proposal, please call our Member Service Center at 1-800-AMA-3211.

The American Medical Association
on behalf of member physicians and their patients.





A Guide to "Medicine in the Year 2002" Physician Participants



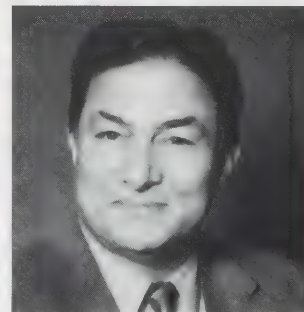
Tama D. Abel, MD
Ann Arbor Family Physician
Member, AMA Advisory
Committee on Concerns of Women
Physicians



John R. Addy, MD
Lansing Obstetrician/Gynecologist



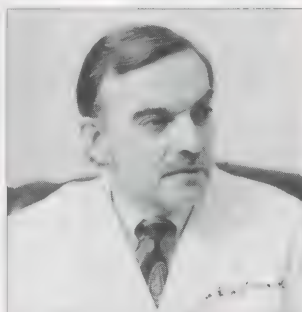
Susan H. Adelman, MD
Detroit Pediatric Surgeon
Member, AMA Council on
Medical Service



Busharat Ahmad, MD
Monroe Ophthalmologist
MSMS/AMA Delegate
Chairman, AMA IMG Advisory
Committee



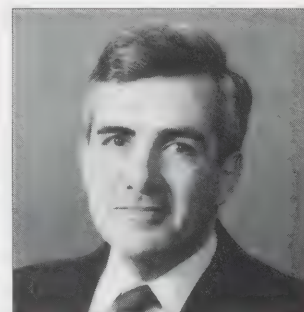
R. Jack Chase, MD
Grand Rapids Internist
Member, MSMS Board of
Directors



Carlo A. Dall'Olmo, MD
Flint Vascular Surgeon
Insurance Liaison - Michigan
Vascular Society



Peter A. Duhamel, MD
Rochester General Surgeon
Member, MSMS Board of
Directors
Chairman, MSMS Board
Legislative Policy Committee



Paul O. Farr, MD
Grand Rapids Gastroenterologist
Past president Kent County
Medical Society



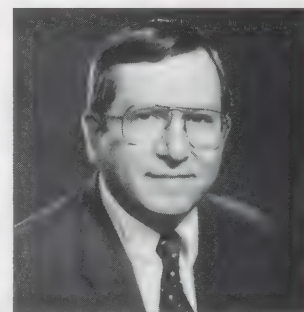
John G. Faughnan, MD
Family Practitioner
MSU Assistant Professor,
Escanaba



Kevin M. Fickenschner, MD
Assistant Dean, President/CEO,
MSU Kalamazoo Center for
Medical Studies



Carl F. Hammerstrom, MD
Marquette internist/pulmonologist
Member, MSMS Board of
Directors



Charles R. Henry, MD
Grand Rapids ENT/Head & Neck
Surgeon; President, Kent County
Medical Society

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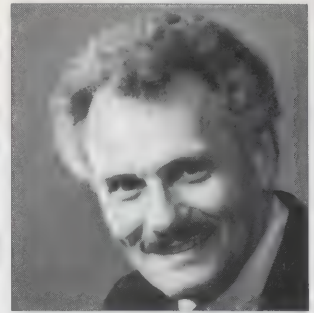
Mark D. Kolins, MD
Grosse Pointe Farms Pathologist
Chairman, MSMS Committee on
Legislation and Regulations



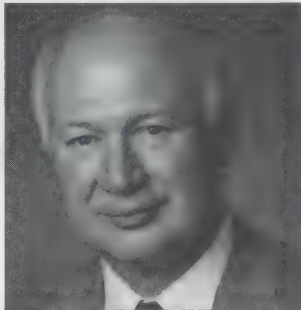
Emily A. Lagace, MD
Family Practitioner
MSU Assistant Professor
Escanaba



Niranjan Lal, MD
Kalamazoo Internist



Douglas A. Mack, MD
Director, Public Health
Chief Medical Examiner, Kent
County



Daniel S. Mazzuchi, MD
Vice President for Academic and
Clinical Affairs and Assistant
Dean, Upper Peninsula Health
Education Corporation,



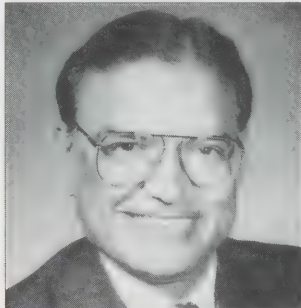
W. Peter McCabe, MD
Grosse Pointe Woods Plastic
Surgeon; Member, MSMS Board
of Directors



AppaRao Mukkamala, MD
Flint Radiologist
Chairman, MSMS Section for
International Medical Graduates



Kenneth E. Rowe, MD
Health Officer/Medical Director,
Western U.P. and Dickenson-Iron
District Health Departments



Krishna K. Sawhney, MD
Detroit General Surgeon
Member, MSMS Board of
Directors; Chairman, MSMS
Hospital Medical Staff Section

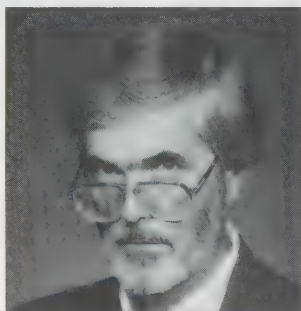


Willard S. Stawski, MD
Director, Undergraduate Surgery,
MSU College of Human Medicine
- Grand Rapids; Board Member,
MSMS, PROM, BCBSM



John "Kevin" Sullivan, MD
Vice President, Medical Affairs,
Port Huron Hospital

Not pictured are:
John E. Bannow, MD
Donald S. Beam, MD
James V. Buzzitta, MD
Michael D. Chafy, MD
Patrick J. Droste, MD
Phillip F. Frantzis, MD
Carol Krieg, MD
Joseph S. Moore, MD
Michael J. Parks, MD
John Petrasky, MD
W. Archibald Piper, MD
Louis E. Sanford, MD
Ali Sawaf, MD
Satish Shah, MD
Frederick W. Sherrin, MD
Craig A. Wheeler, MD



Allen F. Turcke, MD
Flint Radiologist



Joseph J. Weiss, MD
Livonia Rheumatologist



B. David Wilson, MD
Kalamazoo Internist; Member,
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Primary Care Physicians To Play a Significant Role in 2002 **Recruitment, training needs to begin now**

Without a doubt, primary care physicians will play an important role in the delivery of health care in the year 2002. Every physician surveyed projected this to be the case. However, several physicians voiced concern over the need to begin training primary care physicians now to ensure a sufficient supply by 2002. Following are some of the key concerns expressed by these physicians.

"Access to care will only be as good or better than it is now if we are able to produce the number of primary care physicians needed. That would mean that we are counting on the physicians entering their college years by 1994...It is frightening when you consider that the provision of quality care in 2002 depends upon what we do as a society in the next few years. If medicine loses its independence, its lifestyle or its standards, we may adversely influence the future."

— **Louis Sanford, MD**

"It is difficult to survey the American health care scene and not feel the tremors of change. Most people I talk to expect major change and soon...Access to care remains a growing concern, not only because of cost, but also because today's physicians are leaving both rural America as well as its inner cities. It seems that the time for a national health plan has arrived...What disturbs me most of all is the agonizing slowness with which most of our medical education programs have responded to the challenges imposed upon it by these coming changes. We are still producing ever-increasing numbers of high tech, highly-specialized, disease-oriented procedurists, all of whom expect to be richly rewarded for their endeavors. Last month's AAMC data report indicates that nine percent of the 1992 gradu-

ating class of American medical students expect to become family physicians and two percent general internists. Imagine two percent! This trend should scare the pants off all of us. Here we have a system pouring out doctors whose costly trade will most certainly be curtailed by any national health plan which is driven by a concern for controlling health care costs. What will they do? Where will they practice? At the same time, we are not even replacing the short supply of primary care physicians who currently serve us. Who will our doctors be? Where are the incentives to keep young men and women interested in taking care of us?...I believe that our new health care system will be built around the generalist, will pay him better, will reduce his paperwork, and will address the terror of malpractice."

— **Daniel S. Mazzuchi, MD,**

"In the year 2002, the pendulum will begin to sway toward the primary care physician. In the 10 years leading up to that date, we need to create the incentives to make primary care more attractive than the subspecialties which predominate our medical students' attention. As incentives develop, the medical students coming through the pipeline will make primary care a more logical choice."

— **Paul O. Farr, MD**

Better reimbursement needed

"I expect there might be some very significant problems because the life of the primary care physician in our community may not really be attractive to a lot of medical students. I think there's going to have to be some way to provide better reimbursement for the physicians who are in the community, available 24 hours a day, as compared to somebody who is in a larger regional center who may have a house staff and those kinds of things to lighten their load and give them some time off and have a little better quality of life."

— **Kenneth Rowe, MD**

More incentives needed

"When I go around and talk with physicians in internal medicine practice, family practice or rural practice, they are not getting a great cascade of benefits out of the RBRVS system. As I talk with our senior residents in surgery, for example, who are trying to figure out where they are going to go and practice, I find they are carrying \$60,000 and \$70,000 and \$80,000 worth of debt. People are not going to go into practices where they are going to have to spend 10 years recouping the debts they've incurred in medical school and residency and try to raise a family on top of that. So, I think there has to be a tilt towards the family practitioner and primary care and it is not significant yet."

— **Willard Stawski, MD**

"I live in a city (Grand Rapids) that is surrounded by a very rural population and we have had hospitals close and we have had physicians leave practice. How are you going to get a person to go into one of these areas, obviously undeserved? They don't have anybody, there is no medical care within 40 miles of where they live. Now how do you get a physician to go in there? What incentive are you possibly going to offer him? There is no hospital there, no peer group, nobody you can talk to. His laboratory resources are where? A minimum of 40 miles away."

— **Douglas A. Mack, MD**

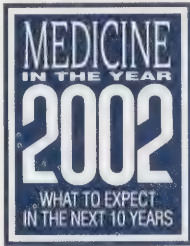
Specialists, Primary Care Physicians, and Other Health Professionals

A look at the issues

By Ralph Ward

Among the changes in health care delivery underway, one of the most professionally difficult is the crossover in services between physicians and other related fields. In the booming field of health care careers, one of the strongest growth areas is for physician assistants. More controversial, though, have been attempts by other health care disciplines and specialties to expand their scope of practice. This year has seen legislative attempts by chiropractors to offer therapeutic treatments and x-ray examinations, and by optometrists to treat eye ailments and to prescribe medications. There is real concern, however, that health care providers may lack the training and certification needed to safely offer these major procedures. While political realities (and, indeed, in some cases common sense) may compel compromise on some of these issues, physicians have an obligation to assure that quality patient care is the guiding principle.

Discussion of the roles physicians fill in our health care structure must include the growing imbalance between primary care and specialty care. According to the AMA, of American's 615,000 physicians, 65 percent are in specialty care, and 35 percent in primary practice. Yet, our urgent need for good primary care, especially in urban and rural settings, grows daily. According to the experience of other developed countries, the proportion of specialists to generalists should be about 50-50. All patients routinely have a primary care physician whom they consult first. To bring our physician structure back into step, about 100,000 physicians should retrain and practice as primary care providers. However, such a massive migration is unlikely to occur out of altruism, and stronger measures by government to direct health careers would bring a health care mutiny. Financial incentives and disincentives offer a more realistic market-oriented solution, at least in the long term.



Physicians Extenders Will Be Prevalent in the Year 2002

The presence of physician extenders will continue to increase over the next 10 years. And, according to many of the physicians polled, both physicians and patients will benefit. Following are some of the comments expressed by physicians.

"The day of the solo cowboy physician is pretty much over. As care gets more complex with increasing specialists combined with increasing concerns of cost, there are going to be more and more ancillary people involved. I think it's going to be more necessary to communicate with such people and not get hung up on either real or perceived threats/concerns about threats to the doctor's authority. Within this, I think disagreements over the scope of practice will be resolved. They have to be. I think partly they're going to be resolved through matters of price competition and others through regulation. I think relatively few will be resolved the way they are now, which is credentialing within the hospital."

— **W. Peter McCabe, MD**

"I think there will be less conflict between physicians extenders and physicians than between specialists and primary care physicians. Turf issues will continue to grow as incomes shrink."

— **Appa Rao Mukkamala, MD**

"I see continued increase in the use of nurse practitioners and physician assistants as physician extenders not only in rural areas, but in urban areas also...I see this as a way of increasing productivity and coverage and access without an exorbitant increase in cost to provide service...With the advent of more complex, more numerous and more expensive medications and pharmaceuticals, I believe there will be a close link between phar-

macists and physicians and would further see strong computer software program backup for both selection and dosage of medications."

— **John "Kevin" Sullivan, MD**

"In low volume areas, general practitioners will still be the dominant primary care providers but with the extensive use of physician assistants. If I get a block of time and I have to maximize my profits for my contracting period, I can do that best by hiring people who are somewhat less expensive than myself to augment revenues."

— **John Faughnan, MD**

"I think we're going to have far more physician's assistants and other people that are not MDs giving care to the patients even in specialty areas. I don't think this is necessarily good but I think it is going to happen."

— **Charles R. Henry, MD**

"We have a circumstance in my own area of practice where there are large numbers of women who are unable to get any prenatal care, anywhere. They have no provider, none. And it is, I think, a gap that will need to be filled. And my anticipation is that it will be filled by nurse practitioners, nurse midwives, people other than physician types."

— **Joseph Moore, MD**



The Physician's Office in 2002

The computer will be your beeper, Doctor

Also, multispecialty group practices will be the order of the day

No topic captured as much excitement as did computerization and its impact on the physician's office by the year 2002. In addition, the opportunity to work more closely with other physicians and other health professionals in multi-specialty group practices seemed to offer a measure of relief from the stresses of solo practice. Following are some of the comments we heard.

"Physicians offices in the year 2002 will be well on their way to being completely computerized. Most, if not all, billing will be done through computers, and it is likely that many of our insured patients will be carrying debit cards that will be linked to mainframe computers allowing for concurrent charges of visits and procedures."

— **Paul O. Farr, MD**

"The capabilities are astounding in billing and patient records and other areas peripheral to the patient contact. This magic can only get better! However, it does reduce privacy for the patient and truly could open the spectre of a big brother computer that does nocturnal patient chart and business audits and lodges automatic disciplinary actions with a copy to the local lawyer. Perhaps we will develop electronic safeguards that give us a modicum of privacy."

— **Louis Sanford, MD**

"What physicians are going to start to realize is that if you get larger you can take advantage of economies of scale and you can bring in staff to help with the paperwork."

— **James V. Buzzitta, MD**

"Filmless radiology departments will (emerge) in the year 2002. Within the next 20 years, they will be a fact of life."

— **AppaRao Mukkamala, MD**

Continued on following page

Practice Management

A look at the issues

By Ralph Ward

The days of the solo practitioner, with secretary, nurse, and old copies of *Highlights* in the waiting room, have largely disappeared. Group practice settings are the norm now. Even these are under stress, however, as physicians feel the growing burdens of paperwork and regulations. Approximately 23 percent of health care dollars in the US are spent on administrative costs, and the smaller the practice, the more acutely this percentage is felt. Every physician has groaned on looking at the pile of insurance paperwork he or she must sign (not to mention the time that went into preparing the forms). The problem will likely grow worse before it gets better.

Of more recent concern is the increasing pressure physicians face from regulatory issues. Medical waste, lab testing and non-infection statutes are causing many of us to reinvent -- at great cost -- how we practice medicine. The Americans with Disabilities Act and new Civil Rights Act create a minefield of unknown liabilities for the physician as an employer. For many years medical practices had little concern about the torrent of regulation engulfing American business. But now, look for this torrent to sweep increasingly into physicians' waiting rooms.

Continued from page 19

"I think small groups and solo practitioners are going to be like high button shoes. Through all of this, however, I still think the physician autonomy will be a one-to-one relationship. You may have to fight for it, you may have to keep the bureaucrats out of it, but I think that if you ask physicians in highly structured countries like England, Germany and France, whether they feel they have autonomy, I think they would all say they do. It just may be a different type of autonomy and we'll have to adjust."

W. Peter McCabe, MD

"I think that in 10 years we're going to find that almost all physicians are going to either be employed by hospitals, HMOs, health care entities or they will, hopefully, have been able to organize themselves into large multi-specialty groups."

—Peter A. Duhamel, MD

"I can see histories and physicals and lab tests going into a computer, the computer actually picking out key words and firing back diagnostic possibilities to you. I think the possibilities are going to be endless."

—R. Jack Chase, MD

"I started out in solo practice and now I've developed a partner and plan on growing larger. One of the main reasons is to cut down on my overhead. It's a lot easier to work

with a larger group and to share in the cost of some of the higher technology items that we purchase. I also think the physicians lifestyle changed. Where we used to spend 60-80 hours a week working, most of the fellows coming out of residency program want to lead a more normal lifestyle with their families and aren't so bent on making the big dollar and want more quality time for themselves and their families. So I think the nature of the doctor coming out of the residency program is a little bit different than it was 10 or 15 years ago when I started."

—Donald Beam, MD

"We are going to see many more multi-specialty practices with professional personnel working along with physicians for reasons of economy, efficiency and effectiveness."

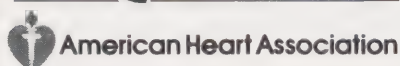
—Michael D. Chafy, MD

"As (physicians) define what their practice goals are, I think they're going to want to give away parts of medical care they don't want or have time to perform so they can more precisely direct their time towards what they want to do."

—John Bannow, MD

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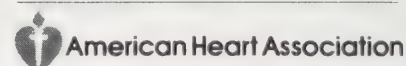
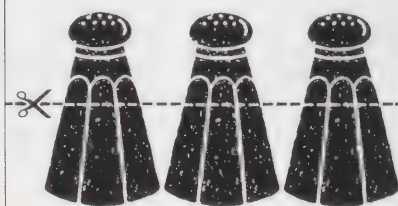
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The Computer and Medicine in the Year 2002.

The next stethoscope is here and it's the computer!

By Kevin Fickenschner, MD

Assistant Dean and President/CEO

MSU Kalamazoo Center for Medical Studies



In 1819 Rene-Theophile-Hyacinthe Laennec published a historical article on auscultation which described the use of a small, perforated wooden cylinder to transmit sounds from the patient's chest to the physician's ear. The small tool that Laennec described came to be called the stethoscope.

The next stethoscope is here and it's the computer! Just like the first stethoscope, the next stethoscope is radically changing our role and responsibilities in medicine.

By the year 2002, the computer will be as integral to making rounds as the stethoscope has been for the last several centuries. The medical computer will be a part of everything involving the clinician. As a palm-sized device, we will carry it with us everywhere we go - a medical diagnostic and communications device (MeDiCom Device). It will serve as the beeper for the next century. It will track us down and serve as a portable telephone, fax machine and computer in one unit.

The MeDiCom 2002 will allow us to contact the National Library of Medicine records for direct access to the latest information. It will carry basic information on all of our patients and allow us to tie into the entire electronic medical record of patients under our care. The electronic medical record of patients will be transportable around the world. It will be available in a large central computer for all clinicians providing care for a patient. Instead of sign-out rounds over coffee in the cafeteria, we will send an electronic report to our colleagues providing overnight coverage via modem. The report will highlight electronically all of the data we are monitoring on particular patients. In the morning, we will receive an electronic update of any change of status.

Sophisticated diagnostic software will also be available for the MeDiCom 2002. Rather than paging through an electronic record in

search of relevant data, we will use software for each patient encounter that allows us to more easily identify the use of incompatible drugs, lab values which are ominous and notations by other health professionals on the status of the patient which need our attention. The MeDiCom 2002 will also provide access to sophisticated diagnostic databases such as digital radiological assessments of a patient's chest x-ray over time, lab studies completed in other communities, and other similar data. Furthermore, every test or procedure will result in an instantaneous cost analysis in an era of constrained resources. The value of what we do will become as important as the process of what we do.

Not only will a computer be used as an adjunct to diagnostic and therapeutic work, it will also become an integral part of education. Through the use of virtual reality, a new and evolving computer technology; we will train medical students, residents and other health professionals to work on complex medical problems. Just as airline pilots use simulators today for learning to fly 747s, so the student of medicine will use a virtual reality simulator to examine patients, make diagnostic assessments and treat clinical problems. These computer simulated experiences will serve to better train physicians in providing the technical aspects of health care.

The physician will not be replaced by the computer, however. The human-to-human aspects of being a physician (i.e. the art of medicine) will continue to be learned in the time-honored fashion of caring for real people. The MeDiCom 2002 will, however, dramatically alter the types of physicians we are training. The generalist will become the physician of the future! After all, you can teach a machine to do all sorts of technical things, but it's hard to teach machines ethics, compassion and the ability to discern the complexity of human life. ■

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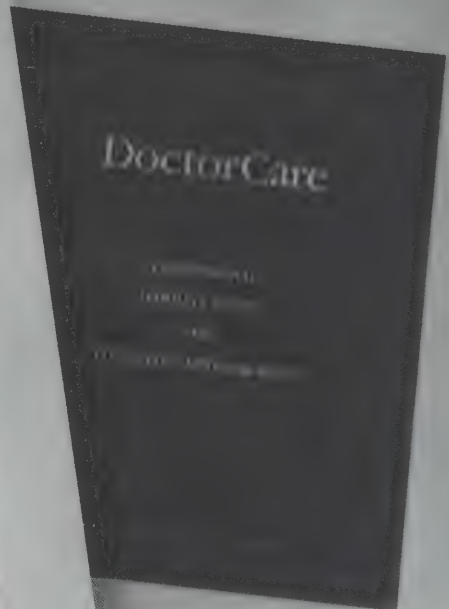
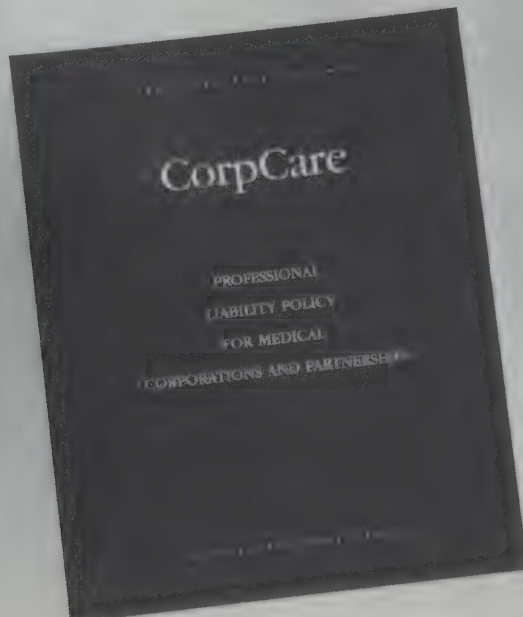
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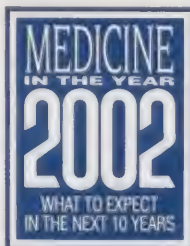
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Physicians to have a stronger role in the prevention of disease, injury, and other public health problems

Many of the physicians we polled looked forward to an era in which they would be much more involved in the prevention of disease, injury and other public health problems. By becoming more involved in prevention, physicians could help to control escalating health care costs, create a healthier society and improve their image.

Most physicians expressed a sense of urgency, though, that physicians need to begin to intervene in areas of prevention right now. Following are just a sampling of the calls for action we heard.

"We've got to get to the accident victim before the accident, the cocaine baby before the cocaine. We've got to get to the person who is involved in an automobile accident before the accident so that they wear their seatbelt. I think if there is any major hope for medicine it would be intervening in the areas of prevention, poverty, hygiene, those kinds of things. It may start in kindergarten, but I think that has to be the redirection, the refocus.

"We have to put in place in our governmental system an incentive, a personal incentive to be well. I think any health care policy that is sold, if you like to drive without seatbelts or not wear a helmet or drive drunk, then you ought to have an incremental payment that comes out of your salary to pay for what is going to happen to you. I mean, if you enjoy anal intercourse, then you oughta pay for it, because the government is going to have to pay for it somehow if you don't."

— Willard Stawski, MD

"I think all of us have to look at approaching the concept of prevention which is now, I believe, a term that is being overused and is becoming trite in everybody's minds...There are many things that can be done that would lower health care costs. As an obstetrician, I can strive to keep a baby out of the neonatal unit even for one day because that is going to save the health care system \$1,300. That is all I have to do. One day, one baby, \$1,300."

— Joseph Moore, MD

"One way physicians can improve their image is to promote the wellness concept...Our image as healers would be tremendously enhanced if we embarked upon a preventative medicine drive similar to the high tech drive that we've had for the past 20 years trying to treat diseases. I don't think it will be hard for us to sell the public on the idea that we are the number one advocate for them, not for our pocketbooks...Doctors have a real image problem and we've got to improve it if we expect to be leaders and expect people to respect us. I think that is one area we can really work on."

— Patrick Droste, MD

Public Health:

A look at current issues

By Ralph Ward

Physicians have expanded their historic concern for public health into many new areas in recent years. Spouse and child abuse, firearm violence, drugs, alcohol and related "lifestyle" issues have seen a growing level of physician concern of late.

Perhaps the strongest, most consistent stand, however, has been on the issue of tobacco use. Ronald M. Davis, chief medical officer, Michigan Department of Public Health, has called anti-smoking programs a priority for the department, yet public awareness that we are blithely murdering ourselves on a large scale has been slow to dawn. Physicians, therefore, have become leaders in the anti-smoking movement.

The latest expression of this has been strong MSMS support for Michigan house Bill 5017, which would restrict the access of minors to tobacco products. It looks likely that the law will pass yet this year.

This is not the only anti-smoking initiative supported by Michigan physicians. A package of legislation, House Bills 5466-67 and Senate Bills 781-783, would increase the state tax on each pack of cigarettes by 25 cents. The outlook for this bill is less certain, however.

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Rationing will be **the** ethical issue in the year 2002

Every physician polled agreed that health care rationing will be the central ethical issue of the next decade. It came up first in every discussion of medical ethics. As noted by the moderator of our five focus groups, many physicians feared the moral quagmire that restricted autonomy presented to physicians, committed on the one hand to addressing patients' health needs with regard for cost and handcuffed on the other hand by payers who have decided that certain treatments will not be covered under any circumstances. Aside from rationing, the next most-mentioned ethical issue was assisted suicide. Following are a selection of the comments we heard regarding ethical issues.

"Shades of Doctor Kervorkian! If we find that we are faced with an overwhelming aged population and no new magic to make life bearable, then the moral issues of taking life may well fade over into the physical and financial issues. We are facing a period of time when as a country we will have a fairly large younger group, a thinning productive middle-aged group, and a very large elderly group. One might project that we could not actually provide adequate care to all based on economics alone (not to mention or include the needed medical personnel). The greatest dilemma in 2002 could be whether to persist with even basic care for diseases of aging."

— **Louis Sanford, MD**

"Biomedical ethics will be one of the major concerns of health care in the next 10 years in a multitude of areas. Certainly one of the most pressing will be the fact that we are spending so much of our health care dollars in the last year of life in a population that is aging and where this resource consumption could expect to increase unless something is done. Tough issues of euthanasia will probably be worked out during this time. Much of ethics behind genetic manipulation, intrauterine diagnosis of disease will be handled. The consensus developed in these areas in the next 10 years will be wrapped into the social policy and the value systems that our country develops regarding health care.

— **John "Kevin" Sullivan, MD**

Continued on following page

Medical Ethics:

A look at assisted suicide

By Ralph Ward

Few topics have grabbed as much recent attention as physician-assisted suicide and euthanasia. The convergence of more extensive, heroic measures to preserve life with an aging population makes the question of when to go quietly into that good night all the more difficult. And from the Karen Ann Quinlan case in the late 1970's to the "assisted suicides" of Doctor Kervorkian today, physicians have been in the middle of turmoil.

The issue of what place, if any, physicians have in ending human life has seen few good answers. Living wills, often touted as a solution in life support cases, are frequently ignored or forgotten when the time comes, according to one study. On the more prickly matter of physician-assisted suicide, a California ballot proposal to permit such suicides in limited cases was resoundingly voted down in November.

In Michigan, the case of Doctor Kervorkian has given the issue of physician-assisted suicide an immediacy found nowhere else in the country. A number of forums on the issue held by MSMS have found that patients seek assisted suicide in part because of unhappiness with the quality of care they are receiving with their degenerative or fatal illnesses. Poor pain control and symptom management, and an overall lack of compassionate care, can leave the already traumatized patient without the will to go on.

In short, too many people are unhappy about the way we die. The need for a public consensus on the issue of assisted suicide is apparent, but the lack of legislative response to the Kervorkian cases stems less from support for his methods than a gridlock over how to respond.

Continued from page 25

"I think government will say to people 'you can have that hip replacement, but we're simply not going to pay for it. Or, if you're 75 we'll pay 20 percent or if you're 85 we'll pay 10 percent, but we're not gonna pick up that bill totally.' Those people who have money will be able to get the service they want, just like it is now in Mexico. If you have money, you can get dialysis. If you have no money, you die of kidney failure."

— Willard Stawski, MD

"There are two ways to ration health care -- in a rational way or in an irrational way. An irrational way is to say we are only going to spend this much money without having a societal effort to decide how that will occur. A rational way is to say that we are not going to do liver transplants except in A, B or C situations...I think that as we analyze the data, we will see that we are spending an enormous amount of money on terminally ill patients and do not change their outcome. My area is transfusion medicine. I know that 50 percent of blood products that I send out of my blood banks go to people that are dead in six months. We collect about 25 million

units a year in this country. That is a huge cost to support people who are not going to be living in the next few months."

— Mark Kolins, MD

"I suspect there will be some national consensus that will allow, under carefully controlled situations, physician-assisted suicide. And I suspect that the health care payers are going to welcome that because it's much cheaper to let somebody die than to keep them alive on a ventilator in the ICU."

— Peter A. Duhamel, MD

"We will have the ability to keep more and more people alive, to prolong life as never before. With this, however, will come many difficult judgement decisions. For example, where will we draw the line with patients whose bodies are good but their minds are gone, or vice versa?"

— B. David Wilson, MD

"I never forget what it means to be a doctor, and what it means is embodied in the American Medical Association Principles of Medical Ethics."

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Genetic Engineering to Top the List of Clinical Issues in 2002

Discussion about genetic engineering generated a wave of excitement for the future. As one physician said, "the thing that is going to be so intriguing about medicine in the next decade is the fact that we're going to go from organ system medicine to cellular medicine. Instead of looking at hearts and kidneys and lungs, we're going to be looking at cells and the makeup of DNA analysis and things like that which will change dramatically."

Other predictions for the future: cures for many cancers, the evolution of new cancers, and resurgence of "bygone" diseases, such as TB.

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Women to Have Positive Influence On the Practice of Medicine

By Tama D. Abel, MD



Will the growing presence of women physicians change the practice of medicine by the year 2002? Most physicians who participated in our "Medicine in the Year 2002" project said yes. Following are the comments of Tama Abel, MD, an Ann Arbor physician who participated in the East Lansing focus group discussion. Doctor

Abel is a member of the AMA Advisory Committee on Concerns of Women Physicians, the AMA Young Physicians Section Governing Council, vice chairman of the MSMS Committee on Concerns of Women Physicians, and immediate past chairman of the MSMS Young Physicians Section.

"Although medicine will remain an important aspect of the life of a physician, it will not be the only one; there will be a growing emphasis on family. A priority for young female and male physicians alike is a life balanced between work, family, and personal needs. A recent survey undertaken by the MSMS Young Physicians Section of young physicians in Michigan (age 40 and under) showed this position with unyielding top priority.

"Women physicians tend to remain primarily responsible for housework and child care, and we see the extraordinary chore of balancing work and family beginning in medical school and continuing through practice.

"More and more medical school graduates

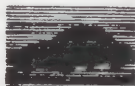
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are female, estimated to comprise almost 30 percent of all physicians in the year 2002. In general, women tend to go into primary care specialties, tend not to go into solo practice, and tend to spend more time with each patient. Almost two-thirds of women physicians are found in five specialties: pediatrics; psychiatry; family practice; internal medicine; and obstetrics/gynecology, and this is not expected to change drastically.

"Women have already changed medicine; maternity (and paternity) leave policies, expanding the time track to tenure in academic institutions, sexual harassment policies, shared positions, child care programs in hospitals, fewer hours at the office and more hours at home, and a choice of primary care specialties are just a few examples.

"Arnold Relman, MD, editor-in-chief of *The New England Journal of Medicine*, wrote in 1989: 'A changing younger profession, more broadly representative of American society, with more moderate income expectations and a greater commitment to the primary care specialties, will be in a better position to meet the needs for health care in the next century.'

"I would add to that excellent summary: The influence of women in medicine is causing a change in the environment where physicians can develop and maintain a balance between their professional, family, and community responsibilities, and also have time for their personal needs. This will ultimately establish a medical community which accommodates the needs of all of its members and strengthen the profession as a whole.

"Personally, I can't wait for the year 2002!" ■

Demographic Trends

By Ralph Ward

The past several years have seen a flood of media interest on the increasingly diverse American population. More and more of those entering the workforce will be female, Latino, black and Asian, and there is much discussion of how society will be changed. Physicians can say they got there first on the issue of diversity, however. Of Michigan's 18,620 physicians (1990), 3,247, or 17.4 percent, are women. While this is unrepresentative of the population as a whole, it puts the equity found in most executive suites to shame. The numbers are even more stark for international medical graduates practicing in Michigan. Over one quarter of state physicians, 27 percent, are from overseas. Look for continued increases in these percentages, especially for women, and for more female physicians in top staff and administrative positions.

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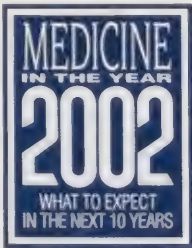


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Medical Liability: Will it be resolved by 2002? It's too difficult to predict

When asked if the medical liability reform issue would be resolved by the year 2002, few of the physicians we polled were able to foresee an end. The physicians were frustrated and tired of the battle with the trial lawyers. Following are just a few of the comments we heard:

"It would be good for all concerned if we could arrive at a 'no fault' arrangement where people that had truly been injured could collect on a prearranged schedule of payments. If the government enacts a Universal Access Insurance Program, then something of this nature funded through Physician Assessment or Insurance might be appropriate. I predict that some progress will be made in this direction. I'm uncertain as to whether it will occur soon enough to ensure a sufficient physician supply for the state's needs."

— **Louis Sanford, MD**

"That (close doctor/patient) relationship some of us who are older felt back in the 50s and 60s may never return...There was a relationship that people wouldn't even think of suing a physician...As medicine gets bigger and more impersonal, it's easier for patients, in general, to sue somebody who is not their physician on a regular basis...I think that is one of many factors involved in the medical liability problem right now."

— **Kenneth Rowe, MD**

"Medical liability will not be a problem if health care is nationalized. If not, some reforms will be built into any health care bills passed by Congress or the states. In general, the situation will improve, if nothing else, because we will be used to it and prepared."

— **Susan H. Adelman, MD**

Continued on following page

Medical Liability:

A look at the issues

By Ralph Ward

There are few issues that draw more heated rhetoric than reform of medical liability. Trial lawyer associations and some consumer groups zealously oppose liability reform, and offer compelling cases of pathetic, injured patients to prove their point. Physicians, however, see the issue from the other side; the soaring insurance premiums, the rising settlements, the hidden but huge "tax" of defensive medicine. Michigan is well known as a high liability state, with an exodus of physicians and medical school graduates to prove it.

Efforts to reform Michigan's present disastrous liability laws have largely generated frustration. A package supported by MSMS, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons was first introduced in the spring of 1991. The proposals, Senate Bills 248 and 249 and House Bills 5434 and 5435, would strictly cap non-economic damages, set higher standards for expert witnesses, and limit attorney fees. In California, similar legislation in the 1970s brought substantial reforms to liability.

The Senate bills passed last year, but the House legislation became mired in the Judiciary Committee. It has remained there since, despite strong coalition efforts to bring the package to a House vote. The results of the November elections could jog the bills out of committee, however.

Continued from page 31

"I personally think that the citizens of the US and Michigan, of course, will start taking a more active role in trying to limit not only medical malpractice but general liability issues that face business (and) companies."

—Charles R. Henry, MD

"We're not actually treating the patient, we're treating the potential complication of possibly missing one little diagnosis and that almost goes against everything we learned in medical school. They teach you how to take care of patients, what to do, the logical things to look for and you almost can't do that when you see somebody coming into your office and the only thing you think is, 'Boy, what if this guy is the one rare case I miss?'"

"As the (public) becomes more aware of what happens with insurance and malpractice liability, I think that's when it's going to start to turn around, when people finally understand what's going on."

— Phillip Frantzis, MD



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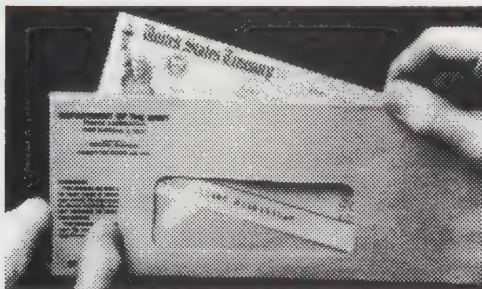
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

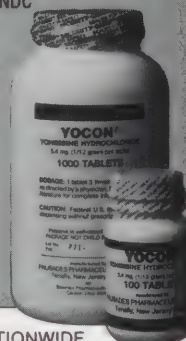
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Health Care Reform Will Likely Come in Exchange for System Reform

Trading a solution for medical liability for some sort of system reform was a theme we heard throughout our focus group discussions. Though many physicians were initially grim about any future resolution to the liability crisis in this state, they did feel some sort of national health care plan would evolve -- a plan that would somehow provide a solution to medical liability. How the health care reform system would evolve and what it would entail was not clearly defined. But, the mere mention of health care reform generated numerous comments. Following is a sampling of the comments we heard.

"I think many more physicians will either be employed or on some sort of capitated reimbursement system where they are paid monthly. I do believe the dual system will remain in which there will be a fee-for-service practice for those more affluent members of our society...Physician autonomy is going to decrease as it has in the last couple of decades. There will be a much heavier emphasis on scientific data, practice parameters and outcome measurements. I think that in another 10 years there will be a lessening of the practice variances that we see in this country and even in this state today."

-- **John "Kevin" Sullivan, MD**

"Group practices will fare best and result in greatest physician satisfaction. It will be unlikely that the solo doctor will be able to provide cost effective care and have available all of the practice tools needed. Greater oversight of practice habits and patterns will be quite evident. Autonomy will be a word in the dictionary."

-- **Louis Sanford, MD**

"When all the tax income of everybody west of the Mississippi goes to pay the deficit interest, health care costs are not the major problem. The major problem is that all the income we're getting west of the Mississippi that could be used to pay for better health care or better welfare care or better schools, I mean if we could take all the money that this government collects west of the Mississippi every year and apply it to public programs, we wouldn't have any trouble."

-- **R. Jack Chase, MD**

"If the federal government controls all the health care dollars...progress will stop, there won't be any more research, we'll be like Canada, like England. When was the last time anything significant came out of any of these countries that have a national health care plan?"

-- **Peter A. Duhamel, MD**

"Some people look at the health care system as really driving the economy. I mean health care is one of the few things over the last five to 10 years that continues to proliferate and really drive the system, creating jobs and market exports in pharmaceuticals. If you look at the GNP a large percentage of that is driven by health care. So there is a positive component to this."

— **James V. Buzzitta, MD**

"Health care as a right is an impossible concept. Basic health care as a right is legitimate, but who is going to define what basic health care is? You can't have everything that you want. There has to be rationing."

— **Allen Turcke, MD**

"The citizens of this country have a tradition of getting health care, by and large the majority of them, whenever they want, and I don't see the citizens really standing pat for or waiting in line for health care. The only way they are going to have any form of care that is timely

and closer to what they are used to, is a care that will be indicated by a second and private insurance sector in addition to a federally-mandated insurance program. In a sense, I see two tiers of medicine evolving."

— **Carlo A. Dall'Olmo, MD**

"I think that before we have a federally-mandated (health care) system, the individual states will have them and there will be some survival of the fittest in that process."

— **John Faughnan, MD**

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Health Care Reform: A look at current issues

By Ralph Ward

Here's a question: Name one political candidate during the last decade who hasn't called for health care reform. I'll save you the suspense. Every political candidate for every office has promised health care reform. None have delivered. The greatest problem with instituting meaningful reform is that everyone with an interest agrees on the need, but then usually falls to blaming others when it comes to solutions. However, a few components seem inevitable.

Some scheme for universal health care coverage is likely within the next several years. President-elect Bill Clinton made this one of the major planks of his campaign. The various "play or pay" programs working their way through the US Congress would essentially mandate employer-paid coverage, either directly or through business taxes. There are several earmarks of "too little, too late" about such plans. Businesses, particularly smaller businesses, complain that they are being forced to pick up the tab for failed

health care reform efforts. Consumer groups note that those who are unemployed or irregularly employed will be left out in the cold. An article in the May 13, 1992 issue of the *Journal of the American Medical Association* (JAMA), laid out several key points for a national health care plan. It must include health education; it must seek to eliminate barriers of culture, language, race and income to quality care; it must be locally based; it must be fully portable; and it must be affordable. Support is building for a full, national health care plan -- as soon as we figure out how to pay for it.

Cutting health care expenditures is another reform priority, but perhaps the most divisive. Physicians, hospitals, regulators, insurers and employers tend to uniformly point to all the other players except themselves as the real cause of soaring health costs. Meanwhile, the national cost of providing health care is doubling every five years. The reforms required will not please

everyone. These will include a greatly expanded system of managed care, more government regulation of health care benefits (current tax policy essentially forces workers and individuals with poor benefits to subsidize those with generous benefits), some system of rationing, greater use of primary care as a lower-cost "gatekeeper," and far less administrative and paperwork hassle. Also urgently needed is serious liability reform.

The physician's place in this reform revolution is less certain. Most discussion of health care reform is based on working with the present system of patient and physician autonomy, i.e., the patient is the best judge of whom to seek services from, and the physician is the best judge of what that treatment should be. Yet many current reimbursement and preferred provider plans threaten this autonomy. Physicians will surely have to fight battles to maintain their authority and special relationships with patients. ■

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Health Access America: A Plan for the Year 2002

By Mary Anne Ford

Speculating about our health care system in the year 2002 brings to mind a story told by Thomas Reardon, MD, AMA Trustee and member of the Physician Payment Review Commission: When Wilbur Cohen, former Secretary of Health, Education and Welfare and a leading architect of our Medicare system, died and went to heaven, he was met personally by God. "Wilbur, it's an honor to have you here," said God. "You've worked so hard as an advocate for health care for the poor and the elderly. Normally, we don't make this offer, but is there anything I can do for you to make your stay here more enjoyable?"

"Yes, there is something I'd love to know," Wilbur Cohen replied. "Tell me, God, will we ever have national health insurance in the United States?" After thinking a few moments, God replied. "Yes, Wilbur, I think we will. But not in my lifetime."

Comments from physicians who participated in interviews about medicine in the year 2002 reveal that most believe our health care system will undergo major changes within their lifetimes. Resolution of some of the problems that burden our current system, prioritization of health care services and massive changes in the organization and delivery of health care are among the predictions for the year 2002.

Physicians are not alone in thinking -- or talking -- about the future of health care. The intensity of voter interest in health care during this election year was certainly unprecedented and health care reform will be a top priority for President-Elect Clinton. The outlines of health care reform released during the campaign will be filled in during the coming months as other reform proposals are studied and elements of Clinton's own plan are given more detail. Observers will recognize pieces of several reform proposals in Clinton's plan.

Continued on following page

How the Proposals Compare

Cost Control

President-elect Clinton: National board sets global budget, exempting managed care plans; states decide how much to spend within budget, with payment negotiations and possible price controls; incentives for managed care expansion in regulated market; more data to consumers to aid plan choice; non-court liability resolution mechanisms; administrative streamlining; practice guidelines; controls on drug prices; more health education; incentives for technology sharing.

AMA Health Access America: Cap on employer tax deduction for health benefits; more insurance cost data to consumers; wide consumer choice of insurance plans; limits on malpractice suits; practice guidelines; elimination of state-mandated benefits; eased antitrust laws to let doctor groups police price gouging.

Access

President-elect Clinton: Phased-in requirement for employers to provide employee coverage, independently or through publicly organized buyer group that includes the poor and uninsured workers; tax credits to help small firms buy coverage; insurance reforms with community-wide rates and guaranteed access; national board sets minimum benefits; expansion of community health programs; Medicare expansion to cover more long-term care.

AMA Health Access America: Phased-in requirement for employers to buy employees coverage, with tax subsidies for small firms; expand Medicaid to cover all below 100 percent of poverty level; sliding scale insurance premiums for those between 100 and 150 percent of poverty; insurance reform with community-wide rates and guaranteed access; expanded long-term care coverage through public-private insurance partnership; tax-deductible health IRAs; state insurance pools for high-risk individuals.

Claimed plan cost and financing

President-elect Clinton: Cost not estimated; no new revenues needed; \$700 billion in cost-control savings by end of decade, plus mandated employer contributions, would pay for plan.

AMA Health Access America: \$23 billion a year added cost to federal government, or \$15 billion a year net cost to nation over five-year phase-in. No revenue sources specified other than mandated employer contributions and cost-control savings.

Sources: *New England Journal of Medicine*; *American Medical News*

Continued from page 37

One plan reportedly under study by Clinton advisors is the "managed competition" plan, introduced by the House Conservative Democratic Forum and Democratic Senators Boren and Breaux. The proposal would mandate employer coverage and have physicians and hospitals competing for the business of group purchasing networks.

Although the President-elect is expected to introduce comprehensive health care reform during the first 100 days of his administration, key Clinton aides interviewed by the *Wall Street Journal* indicate the process could take a year or more and that compromises with Congressional leaders and others may narrow the scope of the President-elect's reform plan. As part of that process, Clinton aides now predict health reform measures that will be phased in over time or perhaps passed in stages.

Still, discussions during the first 100 days of 1993 may be critical to shaping health care in the year 2002. It is an opportune time to review and become familiar with Health Access

“Physicians will recognize elements of Health Access America in health care reform plans introduced at the state and national levels...Health Access America offers a solid foundation for health care in the year 2002... tell somebody about it.”

America, the AMA's proposal for improving our nation's health care system.

Health Access America was first released in 1990; a second edition incorporating several refinements was released earlier this year. It is a plan that calls for action to expand access to health care and control costs, while preserving the strengths of our current system. Its four

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basic goals are to expand health care coverage to all Americans; to control rising health care expenditures; to foster continued excellence in the quality of health care services; and to ensure individual freedom of choice in insurance coverage and health care.

Of the 35 million Americans without health insurance the majority are workers and their families. Most are poor or near poor, but not covered by Medicaid, which only covers 40 percent of those in poverty. An estimated three million Americans are considered "medically uninsurable" because of medical conditions.

AMA proposes several reforms

To assure that all Americans have access to affordable health care coverage, the AMA proposes several reforms:

- Phase in a requirement for employers to insure all employees and their families, with tax help and other incentives for employers;
- Enact Medicaid reform providing uniform coverage to all Americans living below poverty level;
- Implement insurance market reforms, including community rating, guaranteed renewability of coverage, elimination of pre-existing coverage limitations and creation of reinsurance pools;
- Create state level risk pools to make private sector coverage available for those who remain uninsured; and
- Enact major Medicare reform to create an actuarially sound prefunded program with enhanced catastrophic coverage.

Health care costs are driven by many factors: inflation; technology; broad-based insurance coverage; defensive medicine; excessive administration and health conditions associated with growing societal problems such as violence, drug abuse and poverty. Cost containment measures advocated through Health Access America address many of these issues:

- Foster competition in the marketplace and empower patients with information to select coverage plans and to choose physicians and hospitals;

Continued on following page



"Ron's Rule—I give myself one week to meet new people and start having fun on a locum tenens assignment. It hasn't failed me yet."

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- Repeal or override state-mandated health benefit laws, while assuring through legislation that a minimum benefit package is available to everyone;
- Implement medical liability reforms, including alternative dispute resolution mechanisms and tort reforms;
- Curb administrative costs through uniform claim forms, electronic bill processing and reductions in review requirements;
- The amount of employer-provided insurance that is tax exempt and provide tax-free rebates to employees who select less costly health insurance plans;
- Develop practice parameters to ensure that only appropriate health care services are delivered; and
- Eliminate "balance billing" for all insured patients below 200 percent of poverty.

Finally, Health Access America echoes the concern of physicians who participated in "Medicine in the Year 2002." Health promotion and disease prevention are essential to improving the quality of life and to controlling

health care spending. Health Access America reiterates the AMA's commitment to reduce or eliminate health problems related to smoking, alcohol and drug abuse, violence and other problems.

Physicians will recognize elements of Health Access America in health care reform plans introduced at the state and national levels. Many physicians will participate in discussions with community, business, consumer or political leaders who have a stake in the health care reforms that will be debated in the next 100 days, the next 10 years and beyond. Health Access America offers a solid foundation for health care in the year 2002...tell somebody about it. ■

Mary Anne Ford is manager of the MSMS Department of Medical Economics and Health Care Delivery. For a copy of the AMA's Health Access America plan, or for more information on other reform plans, contact Mary Anne at MSMS.

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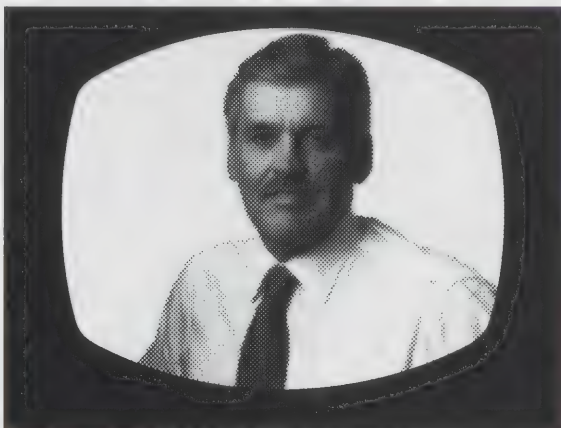


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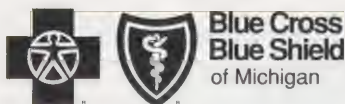
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Sometime during the holidays, I hope we all reflect on the fact that there are doctors and nurses and hospital workers who are not at home for the holidays. They are working hard to take care of us.

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Physician Image in the Year 2002. Will it be positive? Maybe...

Discussion among the physicians we surveyed was intense and lively when it came to projecting what the public's perception of physicians would be in the year 2002. While some thought it would deteriorate, many others were more confident it would improve, *if physicians took certain measures now to improve their image*. "Physician image is in our hands," was the message expressed by these physicians. Following is some food for thought offered by these physicians.

"Physician image in the year 2002 will be directly proportional to the amount of contact physicians have with their patients. The physician solely as a technician will not enhance our image, whereas daily contact with patients and firm advocacy for their benefit will keep us at the forefront of change in health care."

-- Paul O. Farr, MD

"Hopefully, physicians will not be recipients of the blame for a country unable or unwilling to pay its medical bills. If primary care physicians are not adequately compensated for their care, if the malpractice (crisis continues) and we are not able to entice qualified people into primary care practice, then I foresee that the few physicians that are on the job will be supervisors of clinics. They will become the persons setting the business and care principles. They will oversee large groups of nurse practitioners or physician assistants. In the long run, the personal quality will be gone from medical care and clinics will be mills of ritualistic behavior toward patients...Few students will look upon medicine as a desirable career and the physician will be viewed by the patient in the same endearing way the patient views the manager of a (fast food) restaurant."

-- Louis Sanford, MD

"Physician image will continue to deteriorate until the cost of medical care is brought under control and significant steps are taken by the medical profession to teach compassion, human relations and feelings of the patient."

-- Krishna K. Sawhney, MD

"Physicians will always be seen as the best educated, most authoritative figures in health care, but they will share with nurses the image of primary care givers. Whether or not physicians are viewed with affection and respect or with anger and suspicion will depend on the way physicians react publicly to health care reform. If we project our concern for the welfare of the public, they will respect us. If we project self-interest, they will not."

-- Susan H. Adelman, MD

"(Physician image) is the one thing that is entirely in the hands of the physician. We can blow it or we can make it."

-- R. Jack Chase, MD

"Unless there is extensive public education in society and from physicians to change their image, I don't think we will be viewed much differently than high-tech people."

-- Niranjan Lal, MD



Calls for Action

Several calls for action were heard from physicians who participated in this survey. Following are some of the most significant and impassioned pleas we heard.

We must maintain strong patient relationship

"Physicians will still be leaders of the health care team in the year 2002. Leadership will be directly proportional to participation in patient care. If we decide to delegate all patient education to other health professionals, we will be relegated to the rank of technician. We must maintain our close contact and cherish the physician-patient relationship.

-- Paul O. Farr, MD

We must realize we all are on the same team

"I could use the quote from the cartoon character, Pogo, where he says, 'I have met the enemy and the enemy is us.' I think that applies to us...We physicians basically cause more problems for ourselves and I think we have to realize we are on the same team, we are working together here...So I see the future bringing collaboration in the closest setting, which is in the development of large groups, large multi-specialty groups."

-- James V. Buzzitta, MD

We must become more politically active

"The only way the (liability crisis) will change is if physicians become politically active. When we get more doctors making the laws, more doctors in positions of power, then I think things will change. I don't think anything will change as long as attorneys run the country."

-- Patrick Droste, MD

Public attitudes must change

"There has to be a change in the attitudes of the people who live in this country, because right now they're being bombarded with ads in the newspaper that say, 'Did your doctor do

something wrong, might he have done something wrong, could he have done something wrong? Contact Blow Joe and he will find out for you.'...I think the people of this country are bombarded with the attitude that physicians make too much money, that they are greedy, and they make a lot of mistakes, and the lawyers are there willing to help them solve the problem. As long as the people think that way and the trial lawyers are promoting it, there is not going to be any resolution to (malpractice).

"We're having more and more problems in our practice with families and patients that are demanding better and better results and expecting them, and yet medicine is not an exact science. Much of medicine is an art and there are complications, not mistakes, complications . . . and until the people are willing to accept the fact that complications occur and not everybody has a good result, we're not going to have a resolution to this problem."

-- Frederick W. Sherrin, MD

Public must participate in decision on rationing

"The public wants a rational system by the year 2002. I think the only way we are going to achieve that is by having the public participate in the decision on rationing...With better understanding, the public will participate in this decision along with physicians, legislators, lawyers, and everyone. One cannot do it without the other."

-- Michael D. Chafy, MD

We must begin to prioritize

"One of the things that needs to be done is to begin to prioritize and that in essence will lead to some reallocation of resources. We have to

face the fact that this is not a bottomless well. Society has an expectation that they are going to get treatment no matter what but I think society would come along when they understand that this is not a bottomless well. A country that is \$4 trillion in debt has got to begin to prioritize allocation of its health care dollars otherwise you will just spend money like a drunk at the bar. And unfortunately, we will be controlled by outside parties eventually or be given a pot and told, "divide this up and that is it, that is all you get."

— **Michael J. Parks, MD**

We must change with the times

"We have got to get out of the concept of talking about the good old days. We keep thinking about how good it would have been if things today could have been done the way they were in the good old days. For the student, the residents, the people in training, these are their good old days."

— **Allen Turcke, MD**

Patients need to be educated about health care costs

"Individual patients have to be more responsible for their health care bill financially and they have to be aware of how much the different tests cost...Once that happens we can better define what (tests and procedures) are really necessary."

— **John Bannow, MD**

Physician image is in our hands

"I think the public will view physicians as they view themselves. If physicians continue to think of themselves as professionals in the healing arts and as patient advocates, I think society will view them in that light. If they allow themselves to be caught up in a bitter battle to delay necessary change, focus on monetary compensation and do not participate in building a social consensus we need in health care in this country, they will be viewed as obstructionists. I think how physicians are seen by the public is entirely in the hands of physicians and how they deal with this next decade."

— **John "Kevin" Sullivan, MD**

Medicine will still be a noble profession

Despite the many concerns expressed by the physicians we surveyed, there was a strong sense from start to finish that these physicians were dedicated to their profession — a profession that would never be anything but a noble one. Following are just a few of the more inspirational comments we heard.

"I believe in American medicine. I spend much of my life convincing young people to become physicians. I still believe it is a calling and a privilege. Whatever new (health care) system is in place, those things will not change."

— **Daniel S. Mazzuchi, MD**

"If I had it to do all over again I'd still go into medicine today because I like it. I think it is a good profession, an honest profession and an honorable profession. I love what I'm doing. When I am in the operating room I am very, very happy. I love it. I don't like dealing with the problems that have developed around medicine, but I still like what I am doing."

— **Frederick W. Sherrin, MD**

"The day of the solo physician cowboy riding off on his horse like the Marlboro Man is pretty much going to disappear. We're going to evolve into an organizational physician who nevertheless gets great satisfaction on a one-to-one relationship which is still the essence of medicine no matter what the corporate organization."

— **W. Peter McCabe, MD**

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—Henry Wadsworth Longfellow, 1839

Have you ever bought yourself a shiny, new wristwatch? Or maybe received one for your birthday or Christmas?

Getting a new watch shows a certain faith in the future. With it, we're planning to track the arrival of the future at its constant rate, sixty minutes an hour. It's also a durable good, the purchase of which indicates that we plan to be around for at least several more years.

It follows, therefore, that since we are confident the future is coming, we should plan for it as much as possible. After all, we only get the future we plan for. Or as another poet, Rainer Rilke, wrote, "The future enters into us, in order to transform itself in us, long before it happens."

When you think about it, that's really quite a responsibility. We are the makers of the future in everything we do and say and think. It seems especially incumbent upon us then, to do and say and think what we want the future to be.

Certainly, there are outside forces--including every other being on the planet--which do, say and think things that may be contrary to what we are doing, saying and thinking. On the other hand, there are outside forces--including others in your own profession--to which we can lash ourselves to help us promote what we believe to be the right approach to the future. Even if our agenda is not completely accomplished, at least we will have tried and have enjoyed the camaraderie of some mighty fine people along the way.

Recently, MSMS undertook a thorough analysis of what Michigan physicians are saying and thinking about the future through a series of focus group interviews. This entire issue of *Michigan Medicine* is devoted to the findings.

The one area of unanimous agreement was about the need for health care reform. Physicians talked about the problems in medicine--peer review, third-party payer review, interminable paperwork, inadequate Medicare and Medicaid compensation and omnipresent liability fears. In the end, however, they also said they would do it all over again.

We know the problems exist and it appears the country is primed for health care reform.

"If you want more than you are seeing, call MSMS and ask for it. Use this information.

Now, more than ever, it's important what you do, say and think about the future of health care."

But now the question is, how will things be changed?

President-elect Bill Clinton has promised a revamping plan within his first 100 days in office. From what we know of his plan so far, it is fairly similar to the American Medical Association's "Health Access America" plan which calls for employers to provide health insurance for all full-time employees with tax credits to help pay the toll.

In Michigan, Governor John Engler and possible House Speaker Paul Hillegonds have tort reform high on their agendas.

Continued on following page

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But I don't want to get into the specifics of all the reform proposals in this short article. My goal is to get you involved in the process of change, in the process of directing the future.

In the Clinton campaign, physicians across the nation were actively recruited to endorse the candidate and then work vigorously to get him elected. I believe the President-elect now needs us as much as the nation needs health care reform. Furthermore, I believe our U.S. senators and U.S. representatives need to hear from us in the next several months to help educate them about what we believe is needed in the way of reform. And, of course, I think we have to work hard to educate our patients and the public about what we believe will be the best way to address the issues of cost, access and quality.

Personally, I don't see how any plan is going to evade the nasty question of rationing. And what about managed care? What about physicians going to salaries? What about inducing more medical students into primary care? What about professional liability?

Your county medical society, Michigan State Medical Society and American Medical Association leadership have much in the way of information and arguments on reform. You will be seeing more and more of it in the weeks and months ahead. If you want more than you are seeing, call MSMS and ask for it. Use this information. Now, more than ever, it's impor-

tant what you do, say and think about the future of health care.

I have to finish with this story. Several weeks ago I had dinner with William Abbett, Dean of the Michigan State University College of Human Medicine. He said applications for admission to the medical school are up dramatically, about three for each opening. And about half of the future classes will be women.

This news greatly encouraged me. Despite Michigan's continuing medical liability crisis, despite all of the problems physicians face, and despite many years of steeply declining applications, the best and the brightest of our youth are once again responding to a special calling.

They may not see the incomes they might have had in business or law. They may not be placed on that traditional pedestal. But they will work in collaboration with their patients to relieve suffering, promote prevention and restore health. No matter what the future holds, they plan to be members of the most noble profession on earth.

That makes me want to work even harder to ensure them and their patients the best possible future. ■

Doctor Payne is MSMS president.

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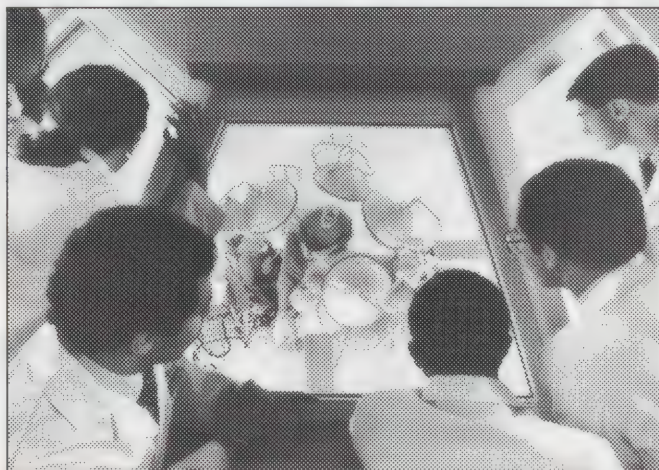
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medical staff of 110 physicians in all medical specialties. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley (metro area of 400,000 people). University of 12,000 students. Competitive financial packages. Contact Christopher Kashnig, Mercy Medical Center, 631 Hazel Street, Oshkosh, WI 54902. Call (414) 236-2430 or (800) 242-5650, Extension 2430. Fax: (414) 231-5677.

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Finding the Right Money Manager



Jim MacDonald is an Investment Executive with PaineWebber in Troy, Michigan.

By James C. MacDonald

Today, there's a new breed of financial consultant—the broker/consultant—who can locate a money manager without undue expense. The broker commission and manager's fee, as well as the monitoring, comparison and analysis programs used by broker/consultants, are paid for by an all inclusive flat fee.

What these broker/consultants do is very similar to what investment management consultants do for major pension funds. They help clients set investment goals and objectives, and then find and monitor the managers who are most likely to meet those objectives.

Broker/consultants use a quantitative approach to begin searching for the right money manager for you. Time weighted rates of return, beta risk analysis and decile rankings are a few of the tools that nationally

networked broker/consultants may use in locating top professional money managers. The statistical measures are only the first step, however. The greatest value in having a consultant is the evaluations of your prospective management firm on qualitative issues.

Through their association within the financial community and their own experience in working with different investment managers, broker/consultants have developed a checklist for use in selecting a money manager. Together, you and your broker/consultant should consider the following:

First, look at the firm.

- Has it been in business long enough to evaluate its investment performance over a full cycle in the financial markets?
- How many dollars has it under management? Does it have clients with needs similar to yours?
- Are the investment decision makers qualified asset managers?

Second, look at the individual manager.

- Does the manager have a proven track record?
- Will the manager devote time to helping your individual investment program?
- Is the manager able to limit losses and risks through a sound capital conservation philosophy?

Faced with the complexities of world financial markets, individuals, trustees, pension fund managers and charitable organizations have long realized that they need help from professional money managers to preserve capital, stay ahead of inflation and obtain superior returns on their investments.

Finding the right money manager, however, can be confusing and difficult. The burgeoning of investment alternatives has created a need for more sophistication when hiring money managers.

Experts say that track record alone is not enough to measure a money manager. How can you find the right advisor?

Increasingly, large corporations and individuals turn to consultants for help in locating an advisor. However, the sophisticated programs necessary to locate money managers and monitor their performance can make these consultants expensive. (Some have minimum fees of up to \$40,000 a year).

Before you make your final selection, you should consider fees. Although fees will vary from manager to manager, annual management fees are usually based on a percentage of assets in the account and will vary based on the size of the account. This is the only fee associated with the account; there are no commissions charged for the trades generated.

In addition to helping you set objectives and find an appropriate money manager, broker/consultants can prove a valuable aid in helping monitor a manager's performance. They receive information on the portfolio and will call a money manager to discuss strategies and changes in your needs. Clients will receive quarterly performance reports from the money manager, as well as account status reports and confirms of trades in the account from the broker/consultant.

The key to successful portfolio management could be at your fingertips. Call your investment executive today, or call Jim MacDonald 1-800-446-0311 for further information about money management.

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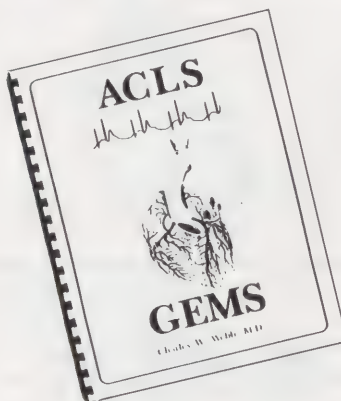
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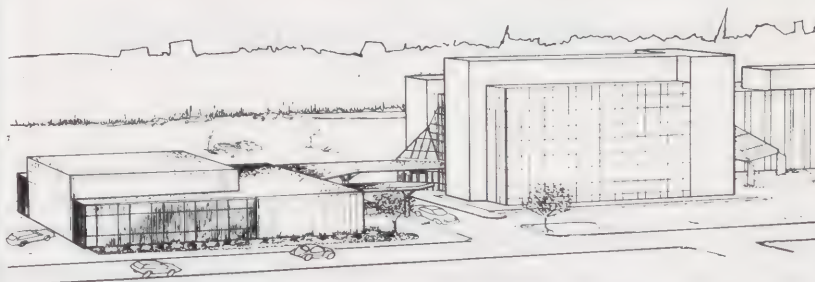
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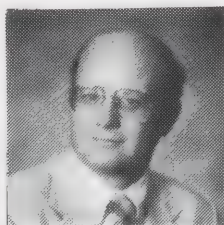
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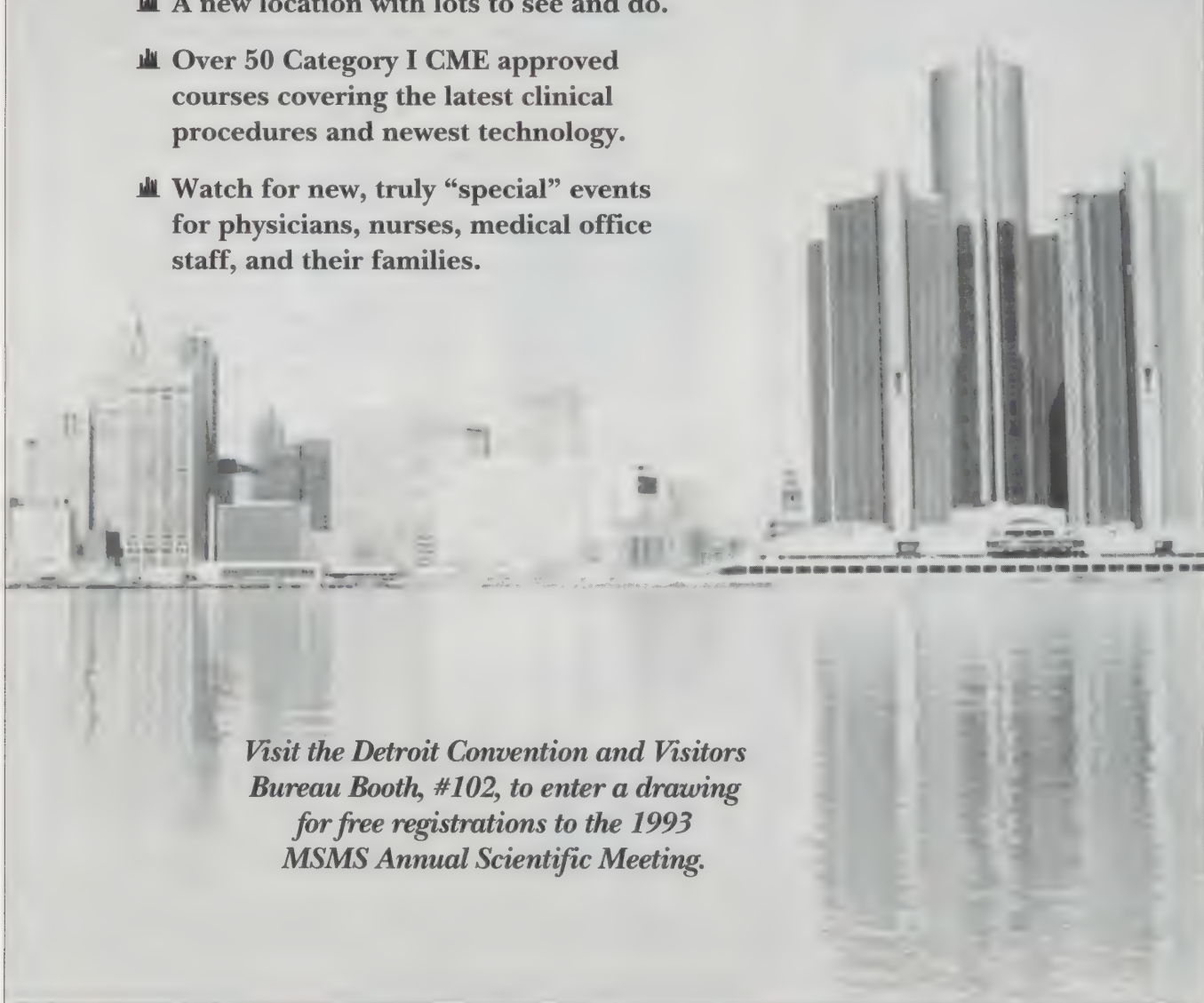
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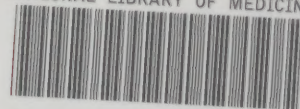
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